Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 3:50^{P™} MARGARET K. SEAY July 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Futurecare Pineview Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 224-14-9843 Director 90 March 8,1918 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at NY New York New York 1 ☐ Yes ♣ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 577 Grand Street 10002 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 Is marked other th <u>Administrative Paralegal City Government</u> traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edloe Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Henderson / Son 840 Chatsworth Dr., Accokeek, MD 20607 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 7/18/08 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Greene Funeral Home 814 Franklin St., Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the as for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Day 5 ☐ Other (specify) the 9 Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page perform certificate 21**X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ∏Yes 2 ∏No investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

P.O. Box 68760 Division or Vital

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINE LEWIER WAKSONF, WAS 12070 Q(A)

WISOBLE 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 2 2 2008

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 26 2008 4:20P M William Clarence Sipple Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4506 Francis Scott Key Highway Taneytown Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours Min 1**X** M 2 □ F 8, 214-32-7773 1936 Maryland Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Xes 2 No Walkersville Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 W. George St. 21793 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 1959-61 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) foreman HVAC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William C. Sipple Sr. Virginia Ramsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark D. Sipple/ son 4420 Mountville Rd. Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation: 7/29/2008 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home ofharine 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examine The law requires that the death certificate be executed and -tran

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u></u>

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, It is Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 687606

P.0.

Division of Vital Records,

To the Hospital or Attending Physician:

physician at s the burial-t attending ph signed by the a peen has this certificate

Physician/Medical ģ Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be P Certification:

2 Accident 3 Suicide 4 Homicide

29a, Certifier

ical

Medi

6 □ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29b. Signa and title of certifie

3

State Registrar (Month, Day, Year, 4



32. Registrar's Signature

completed cause of death (Hom 23a) (T

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death Day Month Physician -23-08 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner TEAL WING CT. APT. 102 DUMRIA HOWARD If Under 1 Year | If Und 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 🗹 i Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD HOWARD COLUMBIA 10e Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: WhITE 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen Important: If Item 27 is marked other the any injury or other treasment. ONSULTENT INSURA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARION JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Sny DER HIAN DR. PASADENA, MD. Z1122 Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 DRemoval from State 2-24-08 HANDVER, MY 5 Other (Specify) 4 ☐ Donation 21. Signatur ess of Facility DaughERTY FAMILY FUNERAL HOME Immediate Cause (Final ardiac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neart pertensive Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trans Atheroscherotic vasular disease Due to (or as a consequence of) attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, pheral e dema 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform severe 051 certificate POROSIA Ü 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/24/08 Mikdashi 0038046

State

Registrar

1000 carredal street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M. Kalashi, MD

31. Date filed (Month, Day, Year)

AUG - 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amended #26 per MD FCHD tam Certificate of Death 7/18/08 Reg. No. 2008 25004 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 13, **Physician** Maurice С. 2008 Tracy 8:17A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick

Vear | HUnder 24 Hrs. Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1**X** M 2 ☐ F 73 Yrs. Director 471-40-9811 April 9, 1935 Minnesota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4409 Highboro Drive Funeral USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Arbitrator US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Clarence J. Tracy Agnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J Tracy/Brother 216305 East Game Farm Road, Kennewick, WA 99337 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/2008 4 Donation 5 Other (Specify) Stauffer Crematory Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licens 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Intral e disease, or composition shock, or heart failure. List only on note that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** rosthe disease or condition resulting in death) /Medical Due to (or as a consecutor **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Yes 2 No 2 1 Nation 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation eral Director: A 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
> Dr. Ronald Miller 4 Culwell Drive, Mt. Airy, MD 21771 31. Date filed (Month, Day, Year)

> > JUL 1 8 2008

29b. Signature and title of certifi

32. egistrar's Signature

State

Registrar

MD

29d. Date signed (Month, Day, Year)

7-16-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT NEAL TAYLOR /Medical Facility Name (If not institution, give street and number, ewn, or Location of Death 4c. County of Death Examiner WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F Months Days Hours Min. 0670371932 76 206-26-6905 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits VA Accomack Greenbackville Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23356 USA 2259 Pike Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 □ No Korea If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No White Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Glass Production Industrial Engineer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Edwards Berle Taylor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Taylor/ Wife 2259 Pike Drive, Greenbackville, VA 23356 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/21/2008 Salisbury, MD 21804 Salisbury Crematory 21. Signature of Funeral Service Licensee 103 Linden Ave. Holloway Funeral Home, P.A. Pocomoke, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PRIMARY a MRTASTATIC CARCINOMA OF UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2116 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No s after death the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ō within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 6" PU BUX 1737 SALISBUMP US 21802 WARY COASTAL HOSPICA HUMM

State Registrar 31. Date filed (Month, Day, Year)

JUL

2 2 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** A M Annabelle E. Troxell July 26, 2008 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Edenton Retirement Community Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 96 Director 217-28-6734 Maryland April 28, 1912 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "naturon" and the traumatic event, he "Medical Examiner must be notified at any or other traumatic event, he "Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Genesis Lane 21703 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Completed by Specify: Specify: 3 Nidowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude C. Trout Rizpah M. Dofler ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Troxell / Son 12504 Circle Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 28, permit. Page Department of Important: If any Injury or Smithsburg Crematory 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine spital or Attending Physician: The law requires that the death certificate be executed nours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (a) 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of ce 29c. License number

State Registrar 30. Name and add

31. Date filed (Month, Day,

Loyd E. Halvorson MD

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

ORIGINAL

Takey Auc

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1475

29d. Date signed (Month, Day, Year) 07/28/2008

			For State	State of Ma	ıryland					lental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Later)	-41		Cei	rtificate	of Dea	ath	2. Date of De	Reg. No.	2008	25007
寒	Physicia /Medic		LEE CLAGETT	WARFIELD	, JR	•				Month July	Day	Year 2008	2:00 P M
).	Examin		4a. Facility Name (If not institution, give					,	tion of Death			County of Death	
150 0	was the second		Montgomery General Security Number 6. S			at histhalasi	OJ If Under 1 Y	ney	nder 24 Hrs.	8. Date of Bir		Iontgome	
Į.	Funeral Director			M 2□F	92	st birthday) Yrs.		ays Hou		May 19	y, Year)	Cou	place (State or Foreign intry) ryland
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits
	Maryli -f sho fied al	to	Md. Montgo	omery	,	Gai	thersbu	ırg					1 □Yes 2 No
	ith the or 28s	Director	10e. Street and Number				10f. Zip Co	de			10g. Citiz	zen of What Cou	intry?
	ath w		20720 Woodfield						0882			nited St	
36	be filed within 72 hours after death with the Maryland tital Hygiene. In a constant the matural, or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1-	was Deceden If Yes, specify 1 \Boxedarian Yes 2		c Ongin? (Spe xican, Puerto ecify:	ecify Yes or No Rican, etc.)	i i	14. Race - Ameri Black, White Specify: W	
2-0036	72 hou natura dical E	eted	15. Decedent's Ed (Specify only highest gra	lucation ade completed)		16a. Dece	dent's Usual C	ccupation	most of worki	ina	16b. Kir	nd of Business/fi	ndustry
2	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work of DO NOT use r Oreman	etired)	mode of work	9	T€	elephone	Company
d 21	filed I Hygi other ent, ti	Be Co	12 17. Father's Name (First, Middle, Last,					18. N	flother's Name	(First, Middle			
ylar		To B	Lee Clagett War	rfield, Sr.	•					. Parsle			
, Maryland	nd 2 sulth ar		19a. Informant's Name/Relationship (Carla B. Warfie							al Route Numb Gaithei —		r Town, State, Zi	ip Code) 20882
altimore,	permit. Pages 1 al Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cei	metery, crei	sition (Name of matory or other Cemeter	r place)		21/08		cation - City or Toshen, M	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licer Muttief A.	Bauher			Name and A Muriel P. O.	ddress of F H. Ba Box 5	arber F	uneral aytons	Home Jille	e, Mđ. 2	0882
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. e.	Do not ent	er the mode o	f dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASPIR			MONIA						Onset and Death
	Examiner			Due to (or as a		ence of):							
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or as a		ence of):						72	
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	CODEOGUE	ance off:							
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_	rtificat ng phy as th		IF FEMALE:								= 1		
P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pregr Other (speci			-	2	23d. Date of deliv Month	very Day Year
	that the	y Ph	Part II. Other significant conditions of	ontributing to death bu	it not result	ting in the u	nderlying caus	e given in F	Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ecords,	w requires that been signed to should be deta	ted by	A.M.I., ATR	IAL FIBRIL	LATIO	N ————				1 🗆	Yes 2	□ No 3 □ Pro	bably 4 🗷 Unknown
Š	siclan: The law in certificate has by irector, page 2 sh	Completed	PREVIOUS C.V							24a. Was auto	osy	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Vital R			DEMENTIA, C.2	A.D.				26.1	Place of Death	1 Yes	rmed? 2.★No	1 □ Yes	2 □ No
	Physiclan: r this certificatal director, i	To Be	examiner? 1 ☐ Yes 2x No	Hospital: 1 ☑ Inpatier	nt 2 E	R/Outpatier	nt 3□ DOA	Other:				Other (Spec	ify)
DIVISION OF	anding Physath. ath. or: After this one funeral dir		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Year)	28b. Time o Injury	f 28c.	Injury at Work? 1 ☐ Yes	1	28d. Describe	how injury	y occurred	
DIVIS	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At hom :. (Specify)	ne, farm, str	eet, factory, or	fice		28f. Location (City or To	Street and wn, State)	d Number or Ru)	ral Route Number,
	he Hospl in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one) 11 Certifying Ph 2	nysician: To the best of niner: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurred at t vestigation, in	he time, da my opinion	ite and place, i, death occur	and due to the red at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	m.n			I	cense num	ber 502	4	29d. Date	e signed (Month	, Day, Year)
١	5+1		30. Name and eddress of person who	completed cause of de			Print)			,	07		
	Sta			32. Registra	≥ M F ur's Signatu				PNIL	ιρ υr.,	OIN	ey, Md.	20832
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:06 July 16, 2008 Bruce Henry Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 74 Nov. 10, 1933 Maryland Director 214-32-8060 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be redified at 1 ☐ Yes 2 No Directo Maryland Montomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12205 Condo A, St. Peter Court 20874 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 X Yes 2 No
If Yes, Give
Year or Dates:1953-56 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Technician Safe Company 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Malcolm Diago Walter Elizabeth Frances Hockman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marjorie R. Walter, wife 12205 Condo A, St. Peter Court, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 7/22/2008 Rockville, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Conse Final disease or condinate on condinate or condinate of the condinate of the condition of th **Physician** Hepatocellular Carcinoma /Medical Due to (or as a consequence of): Examiner Endstage Cirrhosis of Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit Hepato Renal Syndrome P.O. Box 68760, Physician/Medical Acute Respiratory Failure IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify) I TYes 2 TNo 9 Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Jaundice, Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death? has h 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

within 2 To the

10+1

29b. Signature and title of certific

Ganti, MD,

JUL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19529 Doctors Drive,

2008 ▶

32. Registra's Signature

29c. License number

Germantown, Maryland

D41162

29d. Date signed (Month, Day, Year)

July 17, 2008

20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1211445 TTI SULY 11 /Medical 4a. Facility Name (If not institution. give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner USI CTIAL 15 ACTURORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | July 10, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 67 Yrs Coughty) maryland Director 217-42-0166 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits r 28a-f show notified at show Director MD Prince Georges Laurel 1y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or Items 23a or Injury or other traumatic event, <u>the Medical Examiner must be</u> i 8508 Lindendale Drive 20707 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 Black 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home llth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert H. Jackson Grace M. Adams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Saunders (Daughter) 8508 Lindendale Drive, Laurel 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD_Nat'l Mem Park 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 7/18/08 Laurel, MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Part1. Enter the disease, or complications that caused the death, shock, or heart frilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MOR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it dry, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Physician/Medical Examiner be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | → Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s 2 000 1∐ Yes or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ٩ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this nours after death.

ineral Director: After this
y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei Medical and manner stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

30

PAUL PLANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

18

32

		1 - State Registrar		Naryland / De	ertificat	e of L	Death			leg. No.		25 (
Physicia	an	1. Decedent's Name (First, Middle							Month	Day	Year		
/Medic Examin		BARBARA RUTH 4a. Facility Name (If not institutio	n, give street and number	r)	4b City	Town or	r Location of		July	18,	2008 ounty of Death	16:50	p
Examin	ler	Atlantic Genera		,		rlin					rcester		
Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. last birthda		1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth			place (State or	Foreig
Director		149-30-1417	1□M 2X0F	67 Yrs.	MOITING	Days	Tiours	IVIII I.	8. Date of Birtl (Month, Day 8/16/1	940	New	Jerse	У
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						Ţ.	10d. Inside City	v Limit:
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of 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. Ith and Mental Hygiene. Z7 is marked other than "naturel", or iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at	Funeral Director	627 Oxford Stre	et		21	851					USA		
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Ment arke	일	John Sanford						Mon	-				
le m		19a. Informant's Name/Relations							Route Numbe				
ag E E		Joan Smallwood 20a. Method of Disposition	(daughter)						moke Ci		MD 2185 ation - City or To		_
permit. Peges Department of t Importent: If Ite any Injury or ot once.		1 Burial 2 Cremation		20b. Place of Dis cemetery, o									
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Departr Import any Inj		11/11/11	Dens		Hollow	ay F	unera	il Ho	me, Pro comoke	fessio	nal Asso	ciation	
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Medical		resulting in death)	Due to (or a	s a consequence of)!		pen	cten	210	<i>/// /</i>				
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ector, pag		25. Was case referred to medica					20 Bl		1 Yes	200 No	1 ☐ Yes	2 X No	_
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tor: After this certificete ha the funeral director, page	ı.	27. Manner of Death	28a. Date of In			8c. Injury Work			28d. Describe h			<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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efter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 286. Place of I	njury - At home, farm, etc. (Specify)	street, factory	, office		2	28f. Location (S City or Tow	treet and n, State)	Number or Rura	al Route Numb	er,
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within 24 hours effer de To the Funerel Directo completely filled in by th	Medical	29a. Certifier (Check only one) 2 Medical	ng Physician: To the bes Examiner: On the basis	of examination and/or	ath occurred investigation,	at the tim in my op	ne, date an pinion, dea	id place, a th occurre	and due to the o	ause(s) a late and p	nd manner as s lace, and due t	tated. o the cause(s)	
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3 - 8		30. Name and these of norson	who completed cause of	death (Item 23a) (Tur	e. Print)								
To the within 2 To the complete		30. Name ad ess of person Atit Zeesho	who completed cause of ACH 9	death (Item 23a) (Tyc 733 Hcali	Print)	driv	e 13	exli	n M	D 8	11811		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 25, Day 2008 July **Physician** Anne Elizabeth McDougall Young 10:28 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Adamstown Buckinghams Choice Health Care Center B. Date of Birth (Month, Day, Year)
Dec. 29, 1924 Massachusetts Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2√√ 83 022-20-5196 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 21710 3200 Baker Circle, # I-214 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Heath and Mental Hyglene. Int: If item 27 Is marked other than "natural", or items 23. Try or other traumatic event, the Medical Examine must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 CNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Johnson Kenneth McDougall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Clift's Cove Blvd., Madison, AL 35758 Barbara M. Young, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory July 28, 2008 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²Keenev^adid Basford PA Funeral Home MO0255 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metas ato Ovarion Conce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or John Scause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical as attending properties of the second se IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should t Be Completed uper tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun

State Registrar

Hiren Shah 31. Date filed (Month, Day, Year) AUG - 4

29b. Signature

d title of certifier

Thomas Johnson Dr. Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

July 28, 2008

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 687606 24 hours after death Funeral Director;

12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Hosford, M.D., 111 W. High Street, Suite 104, Elkton, MD21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State - 4 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25013 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day 3024 ALTVATER 410 PM DUIS MICHAEL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HUSPICE BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Hours Months Days 217-34-7140 Director 70 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMURE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? HAMPSHIRL 31231 Cass Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be lealth and Mental CHARLES EDWARD ALTVATER ပ VIVIAN WHITE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a WIFE 133 HAMPSHIRE RD BALTIMOVZL OD PATRICIA ALTVATIST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ANATOMY GIFTS RELISTED AULUST 5, 2008 MANOUAR 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7532 CONNELLEY DR. STE. P HANDWAR MY 31076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or se a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Division of Vital 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of e Funeral Direc 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D64395 AURUST 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUR DEBERMAN, MD 6565 N CHARLES ST. SUITE 209 BATTIMITE, NID 21204

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Mo.

5 2008

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	aryiano	epar / נ <i>Certi</i>	tment of F ificate of I	neaith and Death	ivientai my	Reg. N	°2008	25014
Ph	ysicia	20	1. Decedent's Name (First, Middle, Las	it)					2. Date of De	ath	^a 2008 ^{Year}	3. Time of Death 10:45 A.M
//	Medic	al	Rosalie Bryant An 4a. Facility Name (If not Institution, give				th City Toyan o	r Location of Deal		-	C. County of Dea	
Ex	amin		Brighton Gardens	s street and number)			N. Bethe		ui		iontgome	
	eral ector		5. Social Security Number 6. S 578-88-0224 1	DM OFF	e (In yrs. la 91		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year	9. Bir 17 Cat	thplace (State or Foreign ountry) 1ada
land	#		Usual Residence of Decedent 10a. State a 10b. County		10c. City	, Town or Loca	tion					10d. Inside City Limits
Mary a-f sh	fled	ctor	Maryland Montgome	: y	N. E	Bethesda	a					1 □ Yes 2x No
vith the	band	Directo	10e. Street and Number 5550 Tuckerman Lar	#118			10f. Zip Code 20852	-		10g. C	itizen of What Co	ountry?
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland s Hattl and Mental Hygiene. item 27 is marked other than "natural" or items 23a or 28a-f show	minermust	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent & Armed Forces? 1 Yes 2 1 If Yes, Give			as Decedent of F 'es, specify Cuba	dispanic Origin? (San, Mexican, Puer			14. Race - Ame Black, Whit	e, etc.
Z1Z15-UU36 d within 72 hours aff giene. er than "natural".or	al Exa	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Ye ar or Dates:			nt's Usual Occup			16b.	Specify: Wh Kind of Business	nite /Industry
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land Id be fil lental F	ic ever	To Be	17. Father's Name (First, Middle, Last) William Westcott					Adaline				
, Maryland and 2 should be file alth and Mental Hy 27 is marked other	er traumat		19a. Informant's Name/Relationship (and Number or R l, Kensin				
Baltimore, permit. Pages 1 ar Department of Hea	ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. P	lace of Dispositemetery, crema gomery Cr	ion (Name of tory or other plac ematoriu m	, Inc. Aug.	Date 4, 2008		Location - City or nesda, M	
Departi	any Inj once.		21. Signature of Funeral Servi & Licer		00896	kobe 5 755	Vame and Addre Puni Viscon	hrey runer isin Ave.	cal Home/Be	ethes sda,	sda-Chevy (MD 208	Chase, Inc. 14-3501
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/Med Exam				Osteopo:								
7 8	sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ							
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68760, crificate be executed to physician and	the burial-transit	edical		Depress	ion							
O. Box he death cer the attendir	tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🗆 l	Ectopic pregnand Other <i>(specify)</i> _	су			23d. Date of de Month	elivery Day Year
rdS, P. luires that the signed by	should be deta	þ	Part II. Other significant conditions	ontributing to death b	ut not resu	ulting in the und	erlying cause giv	en in Part I.				to the cause of death? Probably 4 Unknown
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	G	2	1 ☐ Yes 2 🖾 No 27. Manner of Death			ER/Outpatient 28b. Time of	3 DOA Oth	4 M Nursing	Home 5 ☐ Res		6 ☐ Other (Sp	ecify)
VISION Attending r death.	fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y, Year)	Injury	Wor	k? lYes 2 □ No	Zod. Describe	IIOW III	ary occurred	
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DIN To the Hospital or, within 24 hours after To the Funeral Dire	pletely fille	Medical (29a. Certifier 1 C tifying Pt (Check only one) 2 Met ical Example 2	nysician: To the best niner: On the basis o and manner st	f examina	wledge, death tion and/or inve	occurred at the t estigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause , date a	e(s) and manner and place, and du	as stated. ne to the cause(s)
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Je .			30. Name and address of person who	completed cause of			rint)	8691 esda. Mar	cyland ?		gust 4,	2000
R	Sta egistr		Ajay Reddy, M.D.) 31. Date filed (Month, Day, Year) AUG 0 5 2	32 Registr		ture 🕡	· · · · · · · · · · · · · · · · · · ·	.544, 1141	- , - 4 11 11 11 11 11 11 11 11 11 11 11 11 1	JJ1		

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - State Registrar		, , , , , , , , , , , , , , , , , , , ,	C	Certificate of Death					Reg. No	. 20	008	3 25	015
1. Decedent's Name (First, Middle, La	st)			2.					th		Vaar	3. Time	of Death
Maria de la	Cruz Cu	ello Ag	üero					Month ugust	3 3		Year 008	7:25	5 P ^M
4a. Facility Name (If not institution, give				4b. City,	Town, or L	ocation of Dea		23	40	. County	of Deat	th	
11800 Old George	etown Ro	ad, #142	7		Nort	h Bethe	esda	ı		Mon	tgon	nery	
5. Social Security Number 6. S	Sex I□M 2 🛣 F	7. Age (In yrs. I	ast birthda Yrs.	Months		If Under 24 Hi Hours Mi	rs. 8. n. M	Date of Birth (Month, Day ay 3,	Year	15	9. Birt Co Ven	thplace (State ountry) ezuela	or Foreign
Usual Residence of Decedent							111	.a, 5,	. .		VCII	CZUCIC	-
10a. State 10b. County		10c. City	, Town or	Location								10d. Inside	City Limits
Maryland Montgo	omery		Nort	th Betl	hesda							1 □ Y€	s 2 🕅 No
10e. Street and Number	-			10f. Zip	Code			1	10g. C	itizen of	What Co	ountry?	
11800 Old George	etown Ro	ad, #14	27		208.	52			V	enez	uela	ı	
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1 X Never Married 2 ☐ Married	1 Tes	2 X No				Specify: $\nabla \epsilon$						e, etc. enezuel	lan
3 Widowed 4 Divorced	Year or D			1 24 100		opeony. Ve	SHEZ	истан					_a11
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unknown 17. Father's Name (First, Middle, Last			362	amstre:		t O. Adatharia Al	/F	irot Middle				Joyeu	-
- ' ' - '				18. Mother's Name (First, Middle, Maiden Surnam Rogella Regella Aguero									
Jose Cayetano Cue			T										
19a. Informant's Name/Relationship (Nancy de la Cruz Meza		anab + ar		-		nd Number or i			-				20052
	cuerro/r				`								20032
20a. Method of Disposition 1 Burial 2 In Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, August 7, Montgomery Crematorium, Inc. 2008											lary1a		
21. Signature of Funoral Service Lice Migalette Can	nsee	м0130	5 I	22 Name a Robert A 7557 Wis	nd Address A. Pump sconsir	of Facility ohrey Fur n Avenue,	neral Bet	Home/I	Beth Mar	esda- yland	Chev 2081	y Chase, 4-3501	Inc.
23a. Part1. Inter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.	n. Do not e	enter the mod	de of dying	, such as card	iac or re	espiratory ar	rest,			Approxim Interval E Onset an	letween d Death
disease or condition resulting in death)	_ a	mia or as a consequ	ience of):									2 Year	:s
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resulting in death) Last	Due to	or as a consequ	uence of):										
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IF FEMALE: 23b. Was decedent pregnant		come of pregna		3 ☐ Ectopic p	oregnancy						ate of del		
in the past 12 months? 1 ☐ Yes 2 🕅 No		ant at time of d		5 Other (s)						M	onth	Day	Year
g □ Unknown	9 L OIIKII	OWII					1						
Part II. Other significant conditions	contributing to de	eath but not resu	alting in the	underlying o	ause giver	n in Part I.		23e. Did to	bacco	use con	tribute to	the cause o	f death?
Hypertension							-	1 □ Y	es 2	No 🔀	3 🗌 Pı	robably 4	Unknown
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25. Was case referred to medical						26. Place of D	eath (C			0 1	TILI TES	2 1140	
examiner? 1 ☐ Yes 2 💢 No	Hospital:	npatient 2 🗆	ER/Outpat	tient 3 D	Othor					6 🗆 Ott	her (Spe	ocify)	
27. Manner of Death		of Injury th, Day, Year)	28b. Time		28c. Injury : Work?			I. Describe h				iony)	
1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		n, Day, Year)	Injur	M		es 2 □No							
3 ☐ Suicide 6 ☐ Could not b	e 28e. Place	of Injury - At ho ng, etc. <i>(Specif</i>)	me, farm,	street, factor	y, office		28f.	Location (S	treet a	nd Numi	ber or Ri	ural Route Ni	ımber,
4 Homicide determined	buildi	ng, etc. (Specify	V)					City or Tow	n, Stai	re)			
29a. Certifier 1 CertifyIng Processing (Check only one)	miner: On the b	best of my kno asis of examina ner stated.	wiedge, de tion and/or	eath occurred r investigation	at the time	e, date and pla inion, death oc	ace, and courred	d due to the oat the time, o	cause(date ar	s) and m	nanner a	s stated. e to the cause	∍(s)
29b. Signature and title of certifier	1	/	A	29	c. License	number		2	29d. D	9d. Date signed (Month, Day, Year)			
town la	bot	Zin K	W)		D4146	0			Au	gust	4,	2008	
30. Name and address of person who	completed caus	e of death (Item	23a) (Tun	e Print\	_								
Francisco Matheu					venue	, Wheat	on.	Marv	land	1 20	906		
31. Date filed (Month, Day, Year)	0-4 11		, micat	,	riar y		. 20						
AUG 0 5		gistrar's Signa	20	1 .									

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician ANESSA BLACKISTON 08 2008 **ク**ヱ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 220-76-4 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director ame 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 🗌 Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working "life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Domes.Ic omemake 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be 1 and Mental ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's e/Relationship (Type. Print) Lepartment of Health at Important: if item 27 is any injury or other traumonce. Wa I 2362 ST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, S 3 Removal from State Romfret 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9 4600 BERT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death typoxemi Dult (or as a corr Immediate Cause (Final disease or condition resulting in death) **Physician** resouration /Medical (or as a consequence of) Examiner neumoni if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of burial-transit law requires that the death certificate be executed and resulting in death) Last Due to (or a a consequence of): certificate has been signed by the attending physician lirector, page 2 should be detached for use as the burit Physician/Medical 68760 IF FEMALE: Box (23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 7 0 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No Yes 2 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \sum Nursing Home Hospital: 2 No 1 Inpatient 1 🔲 Yes 2 ER/Outpatient 3 🗌 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 after death. Director: After this 27. Manner of Deal 1 Natural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Pending investigation Injury 1 ☐ Yes 2 ☐ No Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 5 To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar Name and

31. Date filed (Month, Day, Year)

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

29c. License number

000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 07:13 AM JULY Brown 2008 eronica 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BALTIMORE BALTIMORE GITY NIA | House 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Day, Year) | Min. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 218-60-4544 1 □ M 2 🕱 F **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yes 2 ☐ No Director 1 9 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 1215 ewis TUN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No 2 a 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOUTE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (BUS Jal-.Ourse 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NO21215 Huspand 4019 Lewiston mall 1501 TOS permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARY MOD ARBUTUS Memoral 08 05 Signature of Funeral Service Licensee 22. Name and Address of Facility -K-1 bruell 4600 UBGER CD. mod Doll 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO GENIC SHOCK **Physician** < 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ul morary Edenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Metabolic Acidosis that initiated events resulting in death) Last Acut Hypoxic Despioakery Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Coronares 24a. Was an autopsy Anemia perform 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Natural
2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed burial-trar physician the for use as certificate has page 2 of Vital tor: After this certific the funeral director, Hospital or Attending after death. completely filled in by 24 hours a within 2 To the I

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Maryland

Baltimore,

Veron ca

12 should be fil h and Mental H ' is marked oth

other t

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHARAT RATTAM

31. Date filed (Month, Day, Year)
AUG 0 5 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

MBBS

and manner stated.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RES-000

29d. Date signed (Month, Day, Year) JULY31, 2008

SINAI HOSPITAL OF BALTIMORE

MBBS 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 310A M **Physician** lady /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown BalTimure FuTure Care 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year! 1 M 2 F 219-10-4385 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, tiem 52 remarks 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, III Mixigal Examiner must be notified at MD Yes 2□No TIMORR Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3603 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Biack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICA JURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William OVINA MARU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra Rp Bairs 5123 NO 2 DAS wella Gd-daughter 20a. Method Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 86 08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LUBERTY 24 Re HLOU Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician END - STAGE DISENSE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIONYOPATHY DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CONGESTIVE burial-transi ITCART and Due to (or as a consequence of): attending physician for use as the buria pe Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ HYPERTENSION 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 □Yes 1 ☐Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P safter death. I Director: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061439 08,01,2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COULT RO RANDMISTONN MD 21133 ADEY EMISI 5054N7A 5311 200

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 5

32.

2008

₩egistrar's Signature

Douglas Allen Brooks, Sr. State of Maryland / Department of Health and Mental Hygiene

1- For State

Certificate of Death

2008 25019

	F	Reg. No. Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death											2. Time of Death	
Physicia Medical Exami	ner	1. Decedent's Name (First, Middle,Las Douglas Allen	Brooks, S	r.					, , , ,	Month August 1,	Day Y 2008	ear	3. Time of Death 1852 hrs	
		4a. Facility Name (if not institution, giv 420 South Smallwood Str			41	b. City, Tow Baltimo		ocation of			4c. Count	N	/A	
Funeral Director				1 yrs. last birtho 4 6	iay) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	3/2/6		Foreig	hplace (State or n untry) MD	
Maryland 28a-f show any d at once		Usual Residence of Decedent 10a. State 10b. County MD N/A		c. City, Town or Baltim									10d. Inside City Limits 1 Yes 2 No	
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 2804 Virginia	Ave			10f. Zip Co 2121				11	0g. Citizen of V	What Cour ISA	ntry?	
r death or iter	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Events Armed Forces? 1 X Yes 2 If Yes, Give Year 198	^{No} 1−84	If Ye	es, specify (No	Mexican,	Puerto Rio		Specify	ite, etc. A Amei v:	can Indian, Black, African	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Completed k	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	dı	uring mo	's Usual Oc est of workin	ng life. I	DO NOT u	use retired)	16b. Kind of	truc		
21215-00; ould be filed with I Mental Hygiene s marked other to ic event, the Men	å	17. Father's Name (First, Middle, Last Calvin L. Bro	oks, Sr.					Lett	tie	M. Ma	Maiden Surnar .ckall			
MD 21 od 2 should ulth and Me m 27 is ma aumatic ev	٩	19a. Informant's Name/Relationship (Laquetta Broo		er 2	804	Vir	gin	ia A	Ave,	Balt.	, MD 2	1215		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is in jury or other traumatic.		20a. Method of Disposition 1		20b. Place of Mt cremator	ion 10n	Cem	•	8	8/9/		Balt	c. Location - City or Town, State		
Balti permit. Departm Imports injury o	21. Signature of Furieral Strvice Lensee 22. Name and Address of Facility Hari P. Close F 5126 Belair Rd, Balt., MD 212 23a. Part I. Enter the discesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he											F. S 206-	vs.PA 5105	
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on elimmediate Cause (Final disease	heart	Approximate Interval Between Onset and Death										
kaminer		or condition resulting in death)	Due to (or as a consequ	ence of):										
,	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussion of injury that initiated												
760, ficate be executed g physician and the burial - transit		events resulting in death) Last	Due to (or as a consequ		27		- ~	202 0	10	00				
oe exician	흥	X UNPENDED	AMENDED 23a	,pt.II,	Z/]	per me	e go	א נסט)-1 U- (00 AT				
∞ = ∞ ≈	ਲ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at tin	2	=	tal death ner (Specif	3 [y) _	Ectopic	pregnanc	y	23d. Date Month	e of deliver	y Day Year	
O. Box 6 at the death cer d by the attendi	Physici	1 Yes 2 No 9 Unknow	9 Onknown		in the co			iven in Da		T23e Did t	obacco use co	ntribute to	the cause of death?	
P.O. es that the	Ď	Part II. Other significant conditions Chronic Alcoho	*	ut not resulting	in the u	inderiying C	ause gi	ven III Pal	it.	1 Ye			bably 4 Vunknown	
cords, law require has been sig 2 should b	Completed									24a. Was	psy	prior to	utopsy findings available completion of cause of	
Reco The law cate has	mo;									1 Yes	ormed? 2 No	death? 1 ✔ Y	es 2 No	
tal Rec cian: The certificate	Be	25. Was case referred to medical examiner?	Hospital				10		(Check on		1			
Yit Physical r this of al dire	ToE	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Resid									Residence		r: Scene	
ion of tending Pheath.		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year		ime of li	njury 28		yatWork 'es 2		ou. Describe	now injury acc	Juneu		
Division of Vital Records, pital or Attending Physician: The law requirours after death. reral Director: After this certificate has been stilled in by the funeral director, page 2 should I	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	t be 28e. Place of Injur	y - At home, far	rm, stree	et, factory, o	office bu	uilding, et	c. 2	8f. Location (or Town,		mber or R	ural Route Number, City	
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physi	cian: To the best of my ker:On the basis of examinand manner stated.	nowledge, dear	th occur	red at the ti tion, in my c	ime, da pinion,	te and pla death oc	ace, and di curred at t	ue to the cau	se(s) and man	ner as sta	ted. ne cause(s)	
T. W. D.	29b. Signature and title of certifier							e number	-		29d. Date s	igned (Mo	onth, Day, Year)	
		PayMUS MAN 30. Name and address of person who	bell, MS completed cause of dea	ith (Item 23a)			O.C.N				August 2	2, 2008		
90		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
S Reais	tate	31. Date filed (Month, Day, Year) 32. Egistrar's Signature												

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25020 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BURL Month Day Year KAY BARTON **Physician** AUGUST 2008 4:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1218 NEIGHBORS AVENUE BALTIMORE ROSEDALE If Under 1 Year | If Under 24 Hrs. Hours | Min. 9. Birthplace (State or Foreign Country)
WEST VIRGINIA 7. Age (In yrs. last birthday) 75 Yrs. 8. Date of Birth (Month, Day, Year) 3-2-1933 Social Security Number 6. Sex **Funeral** Days Months 233-48-9016 1**⊠** M 2□ F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 ☐ Yes ¾☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1218 NEIGHBORS AVENUE 21237 U.S.A. 23a death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ; 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FRANKLIN SOUARE permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ins. Ma Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT COORDINATOR 12 HOSPITAL CENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN BARTON MARY E. (KING) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARLENE K. BARTON/WIFE 1218 NEIGHBORS AVE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HOLLY HILL CEMETERY 8-9-08 MIDDLE RIVER, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumonia 3 weeks **Physician** aspiration /Medical Due to (or as a consequence of): Examiner 5tro/ce Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. signed by the a 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð disease 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy certificate 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051349 roma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Suite 205, Veronica Deza MI 9101 Franklin are AUG 0 5 32. Registrar's Signatur 31. Date filed (Month, State 2008 Registrar 1000

08-05695

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25021

Dorothy Eleanor Burk	e State of Maryland / Depart	ment of Health and Mental H ficate of Death	ygiene Reg. No.	2000 2308
R	For State egistrar Decedent's Name (First, Middle,Last)	loate of Boats	2. Date of Death	3. Time of Death
Physician/ Medi-al Examiner	Dorothy Eleanor Burke		Month Day July 25, 2008	0030 1118
	ta. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		County of Death rince George's
	3401 Toledo Terr.	Hyattsville		DD/YYYY) 9. Birthplace (State or Foreign
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Mi		Country)
Director	010-14-2868 1 M 2XF	89 Yrs.	Jan 7, 19	919 Massachusetts
	Usual Residence of Decedent	own or Location		10d. Inside City Limits
w any	Tob. State	yattsville		1 Yes 2 X No
fand fand once.	Maryland Prince George's H	10f. Zip Code	10g. Citiz	en of What Country?
the Maryland or 28a-f sh	3401 Toledo Terrace	20782	30.00	USA
12569 th with the Mary ems 23a or 28a tt be notified ad	11. Marital Status 12. Was Decedent Ever in U.S	. 13. Was Decedent of Hispanic Origin? (14. Race - American Indian, Black, White, etc.
125 ath with items 23 ist be no	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puer	(O Ricall, etc.)	White
ter death ", or iter er must	3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 No specify:	16h	Specify: WITE CE Gind of Business/Industry
urs after aural" anning d by	15. Decedent's Education (operation) only managed	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use no		did of business/mades.y
5 72 hc cal Es	Elementary/Secondary (0-12) College (1-4 or 5+)	Clerical	Fe	deral Government
5-0036 iled within 72 hour Hygiene. d other than "natt the Medical Exan completed	12 17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden	Surname)
filed of the Co.	Charles E. Nyquist		ma Erickson	
Baltimore, MD 21215-0036 256 256 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of		
TD 2 shou and N and S is n matic	Cynthia Edmonds. Niece	1721 Windsor Drive W	inter Park,	FL 32789 Location - City or Town, State
e, N 1 and 1 Health item	ZUZ. MELIOU OI DISPOSITION	Place of Disposition (Name of cemetery, rematory or other place)		
Baltimore, MD permit. Pages I and 2 sho Department of Health and Department of Health and Important: If item 27 is injury or other traumati	1 Burial 2 X Cremation 3 Removal Horri State 4 Donation 5 Other Specify:	tro Crematory Inc.	/04/08 B	altimore, Maryland
Baltin permit. F Departme Importation injury or	21. Signature of Funeral Service Licensee	22 Name and Address of Facility Cremation Societ	y Of Maryla	nd, Inc.
Per T	Thomas Gregor 23a. Part I. Enter the disease, or complications that cause the deat	299 Frederick Ko	ad Baltimor ic or respiratory arrest, sh	e Mary and /1//8 nock, or heart Approximate Interval
Physician	23a. Part I. Enter the disease, or complications that cause the death failure. List only one cause on each line.	Do not enter the mode of dying, cost of	avecavler d	Between Onset and Death
∜ledical aminer	Immediate Cause (Final disease a. Hypertensive	atherosclerotic cardi	ovascular u	Isease
	or condition resulting in death) Due to (or as a consequence or			
i i	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or	f):		
	cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated Due to (or as a consequence of	ff:		
nsit Examine	events resulting in death) Last Due to (or as a consequence of	•		
V ira and cort ∨		perME, G883 9/16/08 T	T	
50, te be exe nysician e burial -		nancy		3d. Date of delivery Month Day Year
rtifica	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of do	2 Fetal death 3 Ectopic pro	egnancy	Month Bay 1995
Box 68760, a death certificate be the attending physic of for use as the burbacician/Mer	1 Yes 2 ✓ No 9 Unknown g Unknown	eath 5 Other (Specify)		
	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I		co use contribute to the cause of death?
P.O.			1 Yes 2	No 3 Probably 4 ✓ Unknown
ds, squire sen sig			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Records, I The law requires freate has been sig			performed	
of Vital Records, ng Physician: The law require Wher this certificate has been si meral director, page 2 should b	25. Was case referred to medical	26.Place of Death (C	neck only one)	
ital ician: s certi	examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other		idence 6 Other: Scene
Phys Prys er this	27 Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred
nding nding th.	1 X Natural 5 Pending	1 Yes 2 N	1	
Division (all or Attending all Directors)	2 Accident Investigation 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, Çit
Division of Vaporial or Attending Phons after death.	determined (Specify)		<u> </u>	
Hospi		edge, death occurred at the time, date and place	e, and due to the cause(s rred at the time, date and) and manner as stated. I place, and due to the cause(s)
To the Hosp within 24 ho To the Funs completely for th	and marine, diates.		12	9d. Date signed (Month, Day, Year)
To wit	29b. Signature and title of certifier	29c. License number O.C.M.E.	1	July 25, 2008
	lacure	-		
	30. Name and address of person who completed clause of death (Ite	_{em 23a)} er 111 Penn Street, Baltimore, M	D 21201	
10	Zabiullah Ali, M.D. Assistant Medical Examin		00	ME
Sta	ALIC A E ZIIIIX MARAONA	It Souls		
Registr	at Hard	ORIGINAL		
DHMH 17 Rev 1/20)1	Oltiona (=		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3 - 20 AM Jacqueline Osborne Buell JULY 31 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A AGINES SATNT HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | 1.7, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 6 Sex **Funeral** New Jersey 1 □ M 2 🂢 F 85 149-14-1188 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show in than "natural", or items 23a or 28a-f show the Medical Exercitive must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 709 Maiden Choice Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mireille Tessier Andrew Osborne ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5792 Stevens Forest Road Apt.23 Columbia,MD 21045 Carol J. Buell, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/01/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 days Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ysician and e burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ing physician a as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) signed by the at d be detached for 1 Tyes 2 No. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 ALZHEIMER'S DEMENTIA 1 Tyes 2 No 3 Probably 4 № Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 □Yes 2 No 1 □Yes 2 × No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 の円 Records, Vital of 0 Division

al or Attending Physician: 3 safter death.
Il Director: After this certifica of in by the funeral director, p completely filled in by e Hospital of 24 hours a To the P within 2.

29b. Signature and title of certifier

6 ☐ Could not be

MD

and manner stated

29c. License number

P22004

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JULY, 31, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUSHA ZYER, 900 S CATON AVENUE, BALTIMORE, MARYLAND - 21229

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) State Registrar

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)





DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ON NO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 22 per in 8883 9-10-08 vt

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

1- State Amend Item 25 per verb. 8882 08/05/08/09 beath Also Items 20, 22 25024 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month July 21, 2008 10:35 AMM Kevin F. Brickman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 12509 Shoemaker Way Gaithersburg Montgomery 8. Date of Birth Pearl Feb 11, 1956 9. Birthplace (State or Foreign New York unk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1⊠M 2□F 52 Yrs 122-48-2187 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√☐ No MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 12509 Shoemaker Way 20878 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:white 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Car Salesman 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Auto Sales Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Francis McGaw unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Colihan/former wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 8/2/08 Beltsville MD 4 □Donation 5 NOther (Specify) -in -state 22. Name and Address of Facility P.O. Box 784 Clarksville, Md State Anatomy Board 655 W. Baltimore Street 21029

Baltimore, MD - 21201 Going Home Cremation Svc. 21. Signalure of Enhoral Son Licensee Waat Wirector 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Regal (Ell Carcinemo metastatic Due to (or as a consequence of): Disegie Prodrp VCDGIA C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner pertension Physician/Medical idpete IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by perlipidemia 2 XNo 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 🔼 Yes 2 🗌 No To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No М 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of ny howledge death occurred at the time, date and place and due to the name (s) and manner as stated.

Certifying Physician: To the best of ny howledge death occurred at the time, date and due to the cause(s) and manner stated. 29a. Cartiflet Medical

The law requires that the death certificate be executed Division of Vital Records, the Hospital or Attending Physician: **Physician**

/Medical

Examiner

Director

by Funeral

Funeral

Director

7 ie marked other than "natural", or Itame 23e or 28a-f show traumatic event, the Mudical Examinar must be notified at

al Hygiene.

Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 Is marked other

5

Depertment of Important: If any Injury or once.

Physician

/Medical

Examiner

attending physicien and for use as the burial-transit

been signed by the should be detached it

s certificate hes l director, page 2 s

s efter death.

I Director: After this d in by the funeral d

director,

filed within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours eft To the Funeral Di completely filled in

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 anti WD 31. Date filed (Month, Day, Year)

AUG 0 5 2008

29b. Signature and title of certifier

(Check only one)



Doctori Drive Gernanteur 20874 Annabe 1

29c. License number

DHILES

29d. Date signed (Month, Day, Year)

70/2 571 5008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** August Edith Alberta Blevins 308PM 2008 02 /Medical 4a. Facility Name (If not institution, give street and number) Examiner De itizens Grace HOME MYSING Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 219-22-5547 Director 82 June 20, 1926 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Harford Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 401 Lee Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Arthur Bailey Wassum Sr. Edna Earl Leftridge ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum 7154 Gardenview Ct., Baltimore, MD 21226 Shirley Kiger / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Bap. Ch. Cem. 8**-6-**08 Bel Air, Maryland Sometime of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neorlasm 17 /Medical Due t (or as a consequence of) Examiner Dements a Sequentially list conditions, Date to for as a nonsequence off Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Due to (or as a consequence of) as the burial-Box 68760. physician Physician/Medical cate has been signed by the attending proage 2 should be detached for use as IF FEMALE If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Yes P.O. 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Michown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 40 24a. Was an performe After this certificate funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many er of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attency within 24 hours after death To the Funeral Director; 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) U 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OFLIGINAL

Bonnie Bonds Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 25026 UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 27, 2008 2210 hrs Medical Examiner MAE ONNIE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore A/K 6301 Quad Avenue Track #3 If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Director 100 Country) MARYLAND 088-30-2600 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ī Yes 2 No s 23a or 28a-f show e notified at once. BALTIMORE Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merkel Hygiene. Important: If item 27 is and coher than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number HILTON 600 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married Yes Specify: Yes 2 X No specify: 3 Widowed Divorced If Yes Give Yea ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) DWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) DALTER ORIS Be GILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) (SON) ROBERT BONDJR. CIRCLE, OWINGS MICLS, MD 21117 36 WELLSPRING 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LANSDOWNE, MD 08/08/2009 MT. ZION CEMETERY Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses IN JR. FUNERAL Kinno FULTON AVE, BACTIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple injuries Immediate Cause (Final disease ⁻xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last t and transit Physician/Medical #I as noted, 23a,27,28a-f, perM,E g882 8/7/08 X UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) ned by the atte detached for u 1 Yes 2 No 9 ✔ Unknown a Linknown can signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of certificate has b rector, page 2 sh performed? death? ✓ Yes 2 1 1 Yes the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred snubject struck by train Certification: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natura Yes 2 X No Pending 7/27/08 10:00 pm Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 6301 Quad (Specify) railroad tracks Ave. Baltimore, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. July 28, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32 Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, 25027 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01, **Physician** 2008 Wilson Basta Bishai, Ph.D. 10:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 118 Charmuth Road Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) May 18,1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 14 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 220-34-4671 85 Director Minia, Egypt Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Maryland Baltimore County Lutherville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21093 United States 118 Charmuth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 TYes 27 No 1 □Yes Ž**□**No If Yes, Give Year or Dates: Specify. White Specify: 5 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor of Arabic Harvard University 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Basta Bishai Fulla Beshara ပ 19a, Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trated once. Elizabeth Ann (nee Gutman) Bishai 118 Charmuth Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04, Aug. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gardens 2008 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr. P. A. 21. Signature of Funeral Service Licensee 2325 York Road 21093 Timonium, Maryland the disease of complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final failure Renal **Physician** mo disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) physician the buria Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d., Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ atherosclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐Yes 2 ☐No 1 □Yes 2 PINO Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 ☐Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident neral Director: , filled in by the f 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 043936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charles St. Baltimore MD 21204 Thomas F. Lansdale MD 6535 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 5 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2008 25028 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year EARL Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Oountry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 X F 231-76-017 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director Ganon 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip-Code ö death with items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Š 3 Widowed 4 Divorced 90 "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 if item 27 i u thei oano Franc injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other 1 Burial 2 ☐ Cremation 3 Removal from State Department of important: If any injury or once. 4 Donation 5 Other (Specify) Home 21. Signature of Funeral Service Lice Se 22. Name and Address of Facility 1 1700MGAKG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final SYNORDM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death in the past 12 months? 3 - Ectopic pregnancy Year Month Day Pregnant at time of death 5 Other (specify) igned by the att 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? has 2 🗌 No 2 _ No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner Other: 4 \sum Nursing Home Y Hospital: 1 Inpatient 3 🗆 DOA 1 Tes 2 ER/Outpatient 5 Residence 6 Other (Specify) မ this (funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of D 28b. Time of Certification: Injury 1 Natural Pending investigation 1 Yes 2 No 2 Accident death. eral Director: A 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours at To the Funeral D completely filled it

> State Registrar

determined

nd manner stated.

GNO JR 1/32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL M. GALVAGNO JR. THE JOHNS

2008

5 0

4 - Homicide

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

29a. Certifier (check only

one)

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

			FUL	partment of Health and ertificate of Death		liene eg. No. 2008	25029
			Negistrar 1. Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death
	Physicia		Joyce Marie Burke		Month 08	O1 Year 200	8 4:30P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea	
	LAUIIIII		6207 Orchard Road	Linthicum		Anne A	runde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho			9. Bir	thplace (State or Foreign ountry) MD
	Director		218-36-3351 1 M 2X F 67 Yrs	. Mondie Baye Hours Willi	02-08-	1941	'MD
	, and		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town o.	Location			10d. Inside City Limits
	sho	ō					1 □Yes 2 No
	the N 28a-f	ect	MD Anne Arundel Linth 10e. Street and Number	10f. Zip Code		0g. Citizen of What Co	ountry?
	with with	Ö	6207 Orchard Road	21090			·
	ns 23	Funeral Director		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	U.S.A 14. Race - Ame	
0	fter d r iten	Fur	1 □ Never Married 2 🛛 Married 1 □ Yes 2 📉 No		to Rican, etc.)	Black, Whit	
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐Yes 2 📉 No <i>Specify:</i>		Specify:	White
12-003p	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, in Modert Explicational behalf and	Completed	15. Decedent's Education (Specify only highest grade completed) (6	ecedent's Usual Occupation	rkina	16b. Kind of Business	/Industry
7		nple	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	9		_
7	filed within Hygiene. other than " ent, tre IVe	ខ	12	Homemaker	me (First, Middle, I	Own]	lome
yland	be fill	Be	17. Father's Name (First, Middle, Last)				
Ĕ	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ins. IM	To	John Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Ri	Elizabet		Zin Cordo)
<u> </u>	d 2 sk th an 7 is r traur		, ,	07 Orchard Road			
a,	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic			sposition (Name of crematory or other place)		20c. Location - City or	L 090 Town, State
<u>ē</u>	ages int of t: If It		1A Buriai 2 Li Cremation 3 Li Hemovai from State	1 00	05-2008	Glen Burn	i a MD
Saltimor	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		4 □ Donation 5 □ Other (Specify) Glen Ha 21. Signature of Funeral Service Licensee	ven Mem. Park US- 22. Name and Address of Facility Si			
ñ	permi Depar Impor any ir		Delema Silk MO1479	1 2nd Avenue SW	Glen Bu	rnie, MD 21	1061
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
	Physician		immediate Cause (Final	1c CARCIN		`	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ic inicin	10011	*	3 917A13
	Examiner		Sequentially list conditions				
7	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
/00/	icate be executed physician and s the burial-transit	al E	Due to (or as a consequence of).				
α	death certificate e attending physic for use as the I	dical	d				
ROX	certii nding ise a	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	liverv
ň	death s atte d for u	iciaı	in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
5	t the by the ache	Physician/Me	9 ☐ Unknown				
s,	s tha gned e det	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
cord	equire en si				1 □ Ye	es 2 No 3 □ F	robably 4 Unknown
ပ္ပ	law ri as be 2 shi	Completed			24a. Was a	24b. Were a	utopsy findings available completion of cause of
<u>r</u>	The cate h	Com			perfor	med2/ death?	s 2□No
VITa	cian: ertific	Be (25. Was case referred to medical examiner?		ath (Check only or	ne)	
0	Physical this of all directions of the control of t	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpi			ence 6 Other (Spe	ecify)
	ding I	ion	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time (Month, Day, Year)		28d. Describe no	ow injury occurred	
<u>s</u>	death death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm		28f. Location (S	treet and Number or R	ural Route Number.
UNISION	after Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide		City or Tow	n, State)	,
	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending promptelety filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, control of the basis of examination and/one) Additional control of the basis of examination and/one one)	eath occurred at the time, date and place or investigation, in my opinion, death occ	ce, and due to the courred at the time, c	cause(s) and manner a	as stated. e to the cause(s)
	Fo the within Fo the complex	Mec	29b. Sighature and title of Otifier	29c. License number	2	29d. Date signed (Mon	th, Day, Year)
	/		In Shaw, m. n	027838	F	306051	4 2008
	6		30. Name and address of person who completed cause of death (Item 23a) (Ty	の27838 pe, Print)			21091
	2		JUMN SHAUGAS, A.D. SIX	CHUL JUND	11 00	, LINITI	neun,nn
	Sta		31. Date filed (Month, Day, Year) 32 egistrar's Signature	1 19			,
F :	Registr		AUG 0 5 2008 Mayer AF A	perez			
L)H	MH 17 Rev 1/2	()()1					

Months

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs

Days

Rockville

Hours

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County Director Rockville Maryland Montgomery 10e. Street and Number 10f Zin Code 9701 Medical Center Drive 20850 Funeral 12. Was Decedent Ever in Ü.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hyman Scharfman Frances Saffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Bravin/ Son 445 Trebo Road, Chester, Vermont 05143 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 30,2008 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stroke **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-tra be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus 1 | Yes 2 | No 3 | Probably 4 ★ Unknown Completed 24a. Was an autopsy performed? res 2 X No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2X No ို 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Sylvia Bravin

7. Age (In yrs. last birthday)

85

2:55PM

Birthplace (State or Foreign Country)

New York

White

Approximate Interval Between Onset and Death 2 years

10d. Inside City Limits

1 X Yes 2 ☐ No

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 3. Time of Death 2. Date of Death Day

Montgomery

United States

Race - American Indian, Black, White, etc.

Pepsi Cola

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month. Dav. Year)

July 28, 2008

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Assisted Living

Month

Bethesda, Maryland

Month

July

8. Date of Birth (Month, Day, Year)

March 15, 1923

27,

2008

4c. County of Death

10g. Citizen of What Country?

Specify.

16b. Kind of Business/Industry

Physician /Medical **Examiner**

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Kingshire Manor
Social Security Number 6. Sex

061-18-9837 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

1 □ M 2 🕅 F

To the Hospital or Attende within 24 hours after death To the Funeral Director:

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check onl one)

29b. Signature and tile of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical

State

Ravi Passf, M.D. 15225 Shady Grove Road #208, Rockville, Maryland 20850-3258

1 ី🏻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28656

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland - State Registrar		rtificate of L		Re	g. No. 20	08 25031
	Physicia	an a	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	LEROY BECKWI' 4a. Facility Name (If not institution, give street end number)	TH	4h City Town or	Location of Death	July	30,2008	
	Examin	er	6216 Liberty Height Terra	nce	Baltir			N/A	204
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
E	Director		220-24-0391 X 79 Usual Residence of Decedent	, 110.			11-18-	1928 [N.Carolina
	aryland show	Ē	,	y, Town or Lo					10d. Inside City Limits 1√2 Yes 2 □ No
	he Ma 28a-f	ecto	Md. N/A B:	altim	ore 10f. Zip Code		10	og. Citizen of Wh	Λ
	death with the Maryland FITS 23a or 28a-f show FITMEST for offined at	al Di	6216 Liberty Height Terra	ance	21207			U.S.A	
	ems 2	nner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.		ispanic Origin? (Spanic Origin?)	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, White, etc.
30	be filed within 72 hours after death with the Marylan tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exhibitor must be notified at	by Funeral Director	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No Il Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		1 □Yes X No	Specify:		Specify:	Black
മാന്ധാ	72 hou natura ileal E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation during most of worki		16b. Kind of Busi	ness/Industry
7	vithin ane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired rinter	1)		Wayor	ly Press
Z	filed v I Hygie other t ent, it	Be Co	17. Father's Name (First, Middle, Last)	F.	IIIICEI	18. Mother's Name	(First, Middle, N		
/land	should be and Menta Is marked aumatic ev	70 B	Williams Beckwith			Pearl_	Ennis		
Mar	12 sho h and 7 Is ma Trauma		19a. Informant's Name/Relationship (Type. Print)			and Number or Run			
	thealth tem 27 l		Marian Beckwith Wife 20a. Method of Disposition 20b. P	6216 Place of Dispo	Liberty sition (Name of matory or other place	y Height	Terra	nce, Ba. 20c. Location - C	1 to , M d. 212 o 7 ity or Town, State
Ē	iit. Pages artment of l ortant: If its injury or o		Burial 2 Gremation 3 Gremoval from State	rriso	n Cem.	8/7/	08	Owings	Mills,Md.
baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic once.	ļ,	21. Signature of Funeral Stry e Licensee MOK	7/ 22	2. Name and Addre Estep I 1300 E1	ss of Facility Brothers 1taw PLa	Funer ce.Bal	al Ser	,P.A. ,Md.21217
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
· A	Physician / /Medical				c Canc	er of p	rosta	re	Onset and Death
	Examiner		Due to (or as a consequence of the consequence of t		remia				
	p #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):					
1	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	juence of):					
o8/60,<	tificate be executed g physician and as the burial-transit	edical E	d						
	ertifica ing ph e as th		IF FEMALE:						
O. Box	e law requires that the death cer has been signed by the attendin e 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1	al death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у		23d. Date Mont	of delivery th Day Year
ت. ت	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
ords	equires een sig ould by						1 □ Ye	s 2 No 3	B Probably 4 ☐ Unknown
I Records,	The law rate has be	Completed					24a. Was a autops perform 1 □ Yes 2	y pr ned3 de	ere autopsy findings available ior to completion of cause of eath? □Yes 2 □No
VItal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deat	> /	-	=
0	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o	of 28c. Injur	ry at	ome 5 Reside 28d. Describe ho		
ion	ending sath. or: Aft	atio	Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury	M 1□	Yes 2 □No			
DIVISION	or Att after de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specific	ome, farm, str	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 1 ertifying Physician: To the best of my knd (Check only one) 2 Medical Examiner: On the basis of examina and manner stated.						
	To the within To the compl	Me	29b. Signature and title of certifier	///	29c. Licens	se number	2	•	(Month, Day, Year)
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	14		30. Name and address of person who completed cause of death liter	n 23a) (Type,	Print)	un UC	2113	3	
	Sta	te	31. Date filed (Month, Day, Year) 32. Begistrar's Signa	ature	0 00	-0 1 1-0-	- (,)		
	Registr	ar	AUG 0 5 2008	S. A.	200				

DHMH 17 Rev 1/2001

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December Company Com	Funeral		5. Social Security Number 6. Sex 7. Age		hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Vear		
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Physician Modicial Examiner Part Physician Phys	m 20799		23a Part 1 Enter the disease or complications that caused the	ne death. Do n	1901 EAST	<u>'ERN AVE</u>	NUE, BA	T.T.T	MORE, MD	. 21231
Due to (or as a consequence of): Due to (or as	Dhysisian		shock, or heart failure. List only one cause on each line	10 B5 01	20/2015 11 12 15			11051,		Interval Between
State State Sequentially list conditions, if any, leading to immediate date, and the property of the propert	/Medical		resulting in death)	consequence	of):	1002	<i></i>			
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FEMALE 23d. Date of delivery 23d. Date of delive	876 ate be hysicia	Cal	d							
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State	dS, uires ti signe Id be c	d by	SIPTSLTS MELLI	TUS	the underlying cause give	en in raiti.				/
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check oply one) 27. Marner of Death 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 28	aw req	olete	BREST CANCE	72					24b. Were autor	osy findings available
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To be an one of the control of the c	anding wath.	atio	2 Accident investigation	rear) In						
30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Z SC DV C S L V V M D	Divis	Certific	determined 289. Place of Injury	/ - At home, far (Specify)	m, street, factory, office					l Route Number,
30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Z SC DV C S L V V M D	the Hoeplin 24 hour	edical	(Check only 2 Medical Examiner: On the basis of e	xamination and	death occurred at the time death occurred at the time death of the death occurred at the time death oc	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s date an	s) and manner as st d place, and due to	ated. the cause(s)
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Pagistras	2		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, Print)	WE PIL	4EISNI	UE	511, DV	CHYMIE
Pagistras	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	0 /200/. 0/,	, , , , , , , , , , , , , , , , , , , ,	- 1 - 7		MO	20832
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DHMH 17 Rev 1/2001 ORIGINAL	DHMH 17 Rev 1/20	01		OF	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Month **Physician** 30 ay 2008^{ear} 1:15P Jane Blankenship Carrol /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 8127 Glen Gary Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 5, 1938 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🗌 M South Carolina 256-52-4899 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marting once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 8127 Glen Gary Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? XM Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hospital Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joiner Floyd Allen Blankenship Lucille 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Niece 8126 Clyde Bank Road Baltimore Maryland 21234 Eve L Greco 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens Aug 2, 2008 Timonium Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the diserse, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vear 400 6'EHR16'S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d, Date signed (Month, Day, Year)

	State Registrar 1. Decedent's Name (First, M.)	liddle, Las	st)		Cer	tificate of	Death	2. Date of Dea	Reg. No.	008	2503
an cal		even	Cornis					July 2			1:45 P
er	4a. Facility Name (If not instit Anne Arunde)			•		4b. City, Town, o		th	4c. County Anne		de1
	5. Social Security Number 143–46–1203	6. S		Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h		lace (State or Foreign htry) NJ
	Usual Residence of Decedent 10a. State 10b. Cou	inty		10c. City,	Town or Loc					11	0d. Inside City Limits
	MD Prin	ice G	eorge's		Bov	10f. Zip Code			10g. Citizen of V	Vhat Coun	1 XYes 2 No
	4022 Emeralo	Lan	ne Apartn	ment D		2071	.8		US	SA	
	11. Marital Status 1 XNever Married 2 □ 1 3 □ Widowed 4 □ Divor		12. Was Decede Armed Forc 1 ∐Yes 2 If Yes, Give Year or Date	es? [X No		Vas Decedent of H f Yes, specify Cuba □Yes 2 XNo	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ k, White, e	
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	12		4		Desi	lgn Engir	•	(F)	Off	ice	
	17. Father's Name (First, Mid						Lydia	me (First, Middle, Douglas		ie)	
	19a. Informant's Name/Relat	, .			19b. Mailin	g Address (Street		lural Route Numbe		State, Zip	Code)
	Rose Cornish	n Sho	owe11 / S				ad, Vine	eland, No		O: T	
	20a. Method of Disposition 1☑ Burial 2☐ Cremati 4☐ Donation 5☐ Othe	r (Specif)	y)	ate Hale	netery, cren	sition (Name of natory or other place Le Method	. 07	Date 5/2008	20c. Location - Haley	-	
	21. Signature of Funeral Ser	vice Licen	*Dorota	Marshal		Name and Address 1501 Eas	L. Steve	ens Funer Avenue, E	cal Home Baltimor	Inc e, M	D 21230
Physician/Medical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the state of th	{	b. Due to (or	ryptoc	nce of):	(seps	is				Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			th 2 Detaildent at time of dea	eath 3	Ectopic pregnand Other (specify)	у			te of delive	ery Day Year
The state of the s	Part II. Other significant con	ditions o		th but not resulti	P .	nderlying cause giv	en in Part I.	23e. Did to	~	ribute to th	ne cause of death? pably 4 🗌 Unknown
	25. Was case referred to med		iómai					24a. Was autop perfor 1 Tyes	rmed? 2 DNo	prior to col death?	psy findings available mpletion of cause of 2 ☐No
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			niner: On the bas and manne	is of examination stated.	n and/or in			curred at the time,	date and place, 29d. Date signe		
	(Check only 2 Med		11/			29c. Licens	e number				Day, Year)
	(Check only 2 Med	rtifier Uni	MS	NO		D5	7078		7/29	108	Day, Year)

			1-	For State Registrar		State	of Mary	yland	/ Depa	artment o <i>rtificate d</i>	f Healt of Dea	h and N <i>th</i>	lental Hy	gien Reg. N	e2008	3 2	5035
			1. [Decedent's Name	(First, Middle	e, Last)	-						2. Date of De	eath			ime of Death
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and Suban	Examir					, give street and r	number)			4b. City, Town	n, or Locati	on of Death		\neg	c. County of De	ath	
				KESWICK							IMORE				N/A		
	Funeral			ocial Security N		6. Sex 1 ☐ M 2 💢 F			<i>it birthday)</i> Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Bi	av, Year) (irthplace (Co <i>untry</i>)	State or Foreign
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	ylanc how		10a	. State	10b. County		10	Oc. City,	Town or Lo	ocation						10d. In:	side City Limits
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	or 28	Dire	10e	. Street and Nun	nber					10f. Zip Cod	е			10g. C	itizen of What C	ountry?	
	ath w	la		1720 GLE	N KEIT						234				USA		
	er de	Funeral		Marital Status		12. Was De	cedent Eve Forces? 2 X No	r in U.S.	13.	Was Decedent of If Yes, specify C	of Hispanic Juban, Mex	Origin? (Sp ican, Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Am Black, Wh 		ian,
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and	be fill ad oth even	Be	17.	Father's Name (Last)							(First, Middle		n Surname)		
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Maryland	d 2 st th an th si traur	Ш		a. Informant's Na コロナミケナルロ		nip (<i>type. Print)</i> TTI/DAUG	UTED							_	or Town, State,	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mydical Expriner mast burnottled at			. Method of Disp		III/DAUG		20b. Plac		MURDOCK esition (Name of matory or other)			TIMORE,	MD 20c. l	21212 -ocation - City o	r Town, St	ate
9	Pages 'nent of hant: If ite			1 X Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from	n State	10REI	netery, crei LAND	matory or other MEM。PA	olace) RK	8/7/	/2008	HIL	LENDALE	, MD	
Baltimore,	#EEF.		21.	Signature of Fur					> 22	2. Name and Ad	dress of Fa	1			JNERAL I	•	P.A.
m	Depa Impo any ir			7						3521 LOC						21286	
		-	23	arus. Entri th	e disease, or t failure. Lis	con dications that	t caused the	death.	Do not ent	ter the mode of	dying, such	as cardiac	or respiratory a	arrest,		Appro	oximate val Between
-	Physician		dis	nediate Cause (lease or condition	Final	1 -	rebo				iccid					Onse	t and Death
	/Medical Examiner		res	ulting in death)			o (or as a co		-			1,1					
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Вох	eath certifi attending for use as	Physician/M		EMALE: . Was decedent in the past 12 r		23c. If yes, o	utcome of p			☐ Ectopic pregna	ancv			- 1	23d. Date of d	-	
0.	the a	sici		1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 □ Pre 9 □ Uni	gnant at tim known	ne of dea		Other (specify					Month	Day	Year
σ.	that the de ned by the detached		Part		cant conditio	ns contributing to	death hut no	nt resultii	na in the u	nderlying cause	given in Pa	art 1	23e Did i	Inhacen	use contribute	to the cau	se of death?
of Vital Records,	uires t signe d be	d by									gironiiir		1		2 □ No 3 □ F		
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ital		Be C	25.	Was case referre	ed to medical						26 PI	ace of Death	1 □ Yes		o 1 □Ye	s 2 🗆 N	0
f V	is dir	To B		examiner? 1 ☐ Yes 2 🖼	10	Hospital: 1] Inpatient	2 🗆 EF	R/Outpatier	nt 3 🗆 DOA	Other:				6 ☐ Other (Sp	ecify)	
	ding Ph h. After thi funeral	L:uc		Manne of Death	5 Pending		e of Injury onth, Day, Ye	ear) 28	3b. Time of Injury	28c. li	njury at Vork?		28d. Describe				
sio	Attendi death. ctor: A y the fu	cati		2 Accident	investig	ation		-		M 1	□Yes 2	□No					
Division	or Attending after death. Director: After in by the funer	Certification:		4 ☐ Homicide	determi	ned 28e. Plac	ce of Injury - ding, etc. (S	At home Specify)	e, farm, str	eet, factory, offic	e		28f. Location (City or To	Street a wn, Stat	nd Number or F e)	Rural Route	e Number,
ш	spital ours a neral I		29a	. Certifier	1 Certifyin	g Physician: To th	ne hest of m	v knowle	edne deatl	h occurred at th	a time date	and place	and due to the	Calleo(s) and manner	as stated	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		(Check only one)	2 ☐ Medical	Examiner: On the	basis of exa inner stated.	aminatio	n and/or in	vestigation, in m	y opinion,	death occurr	ed at the time,	date ar	nd place, and du	us stated. le to the ca	ause(s)
	To th within To th	Me	29b	. Signatur e and t	itle of certifier	2				29c. Lice	ense numb	er		29d. D	ate signed (Mor	th, Day, Y	ear)
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DHMH 17 Rev 1/2001

			For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma	ryland / De	partment of ertificate of	Health and l		Reg. No.	8 0	2503	
Phys			June Rhode Cec					Month August		008	6:30 P	M
/Me Exai	dica		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County			
LAGI	IIIIIC		Rockville Nurs	ing Home		Rock	ville		Mont	gome	ery	
Fune	ral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthd	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da		_	place (State or For	eign
Direct			131-18-0990	□ M 2 🙀 F	87 Yrs	Months Days	Hours Min.	October 2	6, 1920	Nev	w York	
p .			Usual Residence of Decedent		40 - Oit Town or	Lacation					10d Incide City Lie	-14
aryla:		_	10a. State 10b. County		10c. City, Town or						10d. Inside City Lin 1 √2 Yes 2 □	
8a-f		Sct	Maryland Montgom	ery	Rocky							INO
vith th			10e. Street and Number			10f. Zip Code			10g. Citizen of V		1	
ath v		era	303 Adclare Ro		uo I-	2085		'' Maria Mari	Unite			
ING ZIZIS-UUSO be filed within 72 hours after death with the Maryland tral Hygiene. do other than "natural", or items 23a or 28a-f show event, The Mcdical Evaning That India to notified a		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	verin U.S.	 Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☑ No 		o Rican, etc.)	Specify	k, White,	ican Indian, etc. ite	
2 hou attura		g	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occu	upation		16b. Kind of Bu			
in 72 in 72 in "nat	1	Completed	(Specify only highest gra	de completed) College (1-4or 5+	(G	ve kind of work done DO NOT use retire	e during most of wor ed)	king				
Z L		ĕ	Elementary/Secondary (0-12)	4	'	Homemake	er		Own	Home	9	
d be filed ental Hy ked othe		Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surnam	ie)		
Vients Wents rked tic e		9	Frank Levinson				Mario	on Rhode				
Maryland AIAI d 2 should be filed within 7 th and Mental Hygiene. Tranmatic event, In Men			19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Stree	et and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zi	p Code)	
y IVIG			Guy D. Cecala /	Son	730	3 Burdett	e Court	Bethesd	a, Maryl	Land	20817	
GOTE, INTERPLE ges 1 and 2 should tt of Health and Mer If item 27 Is marke or other traumatic			20a. Method of Disposition	D 1/ 0: 1	20b. Place of Dis	position (Name of rematory or other pla eterans Cen	ace)	Date	20c. Location -	City or T	own, State	
Page nent annt: I ury o	.		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>)		Garriso	eterans cen n Forest	etery; August	: 11, 2008	Owings M	ills,	Maryland	
Dallinore, Mig permit. Pages 1 and 2 a Department of Health a Important; If free 27 is any Injury or other trai	once.		21. Signature of Funeral Service Licen	,	0896	22. Name and Addr Bethesda- 7557 Wisc	ress of Facility Rob -Chevy Cha consin Ave	ert A. ase Inc. enue Be	Pumphrey thesda,	Fur Mar	neral Hom yland 208	e/ 14
		1	23a. Part 1. Enter the disease, or comp	plications that caused t	he death. Do not				-		Approximate Interval Between	
Physicia /Medic	_		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Hypert	ensive He	eart Disea	ise				Onset and Death	
Examin				Due to (or as a Dement	consequence of):							
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	consequence of):							
Ited Insit	-	Ĕ	Cause (Disease or injury that initiated events resulting in death) Last	Septic	14.5							
execu execu al-tra	١.	Examiner	that initiated events resulting in death) Last	C	consequence of):							
rificate be executed as the burial-transit		edical		d								
ufficat tifficat g phy as the												_
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of Live birth 2 4 Pregnant at 9 Unknown	Petal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy			te of deliventh	very Day Year	
that the ed by detac	i	Phy	Part II. Other significant conditions c	ontributing to death but	not resulting in the	e underlying cause g	iven in Part I.	23e. Did to	obacco use cont	ribute to	the cause of death'	?
w requires to been signed should be a		ted by	 	· 				1 🗆 \	∕es 2 No	3□ Pro	bably 4 🔼 Unkno	own
The law		Completed						24a. Was autop perfo 1 □Yes	rmed?	prior to co death?	opsy findings availa ompletion of cause 2 No	able of
VII.dli ician: T sertifica ector, pa		Be	25. Was case referred to medical examiner?					ath (Check only o	ne)			_
Physi r this ral dire		0	1 ☐ Yes 2 🙀 No		t 2 ER/Outpa	Helit J DOA		lome 5 Resid			ify)	
ing F		<u>ë</u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	/ 28b. Time Year) 28b. Time Injur	y Wo	ork?	28d. Describe h	now injury occurr	ed		
Attending at death. ector: After by the fune		cat	2 Accident investigation 3 Suicide 6 Could not be				□Yes 2□No					
lor At after c Direct		Certification: 10	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (8 City or Tov	Street and Numb vn, State)	er or Rur	ral Route Number,	
e Hospita 24 hours e Funeral	.	Medical C		ysîcian: To the best of niner: On the basis of and manner stat	examination and/o							
To the restriction of the restri	1	Z E	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signe	d (Month	, Day, Year)	
			Moines	V. Jos	an	חחת	47330		August	4.	2008	
1			30. Name and address of person who				.,,,,,,		1146456			
2			Thomas V. Joseph			nonston D	rive #207	Rockvi	11e, Ma	ry1a:	nd 20852	
F-7-1	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar	's Signature							
Reg	istra	r	AUG 0 5 2	008 Bearing	a the	Crack 1						

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CRAWFORD 9:15p M JULY 31, 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FRANKFORD NURSING CENTER BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕅 F Director 218-54-2212 60 11-23-1947 NORTH CAROLINA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinat must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 XYes 2 No HARFORD **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1941 EDGEWATER DR. 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-WELDER MARYLAND DRYDOCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REGINALD A. CRAWFORD SR. ဥ MATHEL SCALES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRODERICK CRAWFORD (BROTHER) 2410 ERDMAN AVE. BALTIMORE, MARYLAND 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 1 Crematio 3 Removal from State 5 Other (Specify) KING MEMORIAL PARK 8-5-2008 BALTIMORE, MARYLAND JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature o 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s of , or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme (if e Cause (Final diseas or condition resulting in death) **Physician** EMOSPICIE /Medical Examiner munt Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Physician: The law requires that the death certificate be executed /Ands attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) ☐Yes 2 N P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 🗓 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 Ŋ Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of eath 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Mural 5 Pending death. investigation 1 ☐ Yes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Marcian

State Registrar

31. Date filed (Month, Day, Year)

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- Crum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E:	M xa	m	ine
To the Hospital or Attending Physician: The law requires that the death certificate be executed		or: After this certificate has been signed by the attending physician and	ched for use as the bur
the Hospital or Att	hin 24 hours after death.	o the Funeral Director: After this or	npletely filled in by t
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		1 - State Registrar		-	Cer	tificate of	Death		Reg. No.	000	23030	
Physici /Medic		1. Decedent's Name (First, Mi Dorothy C. D						2. Date of De Month 8/3	Day	Year	3. Time of Death 1:20pm M	
Examin	er	4a. Facility Name (If not institu Mays Chapel N	tion, give street and nu ursing Home	imber)		Timoniu			4c. County of Death Baltimo:			
uneral rector		5. Social Security Number 218–18–6481 Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ay, Year)	9. Birthp Coun	lace (State or Foreign try) MD	
8a-f show otified at	Funeral Director	10a. State 10b. Cou	Baltimore	10c. Cit	y, Town or Loc	ation imonium I	MID		10d. lr			
23a or 2 ust be no		10e. Street and Number 12246 Roundwo	od Road			10f. Zip Code 210	93		10g. Citizen	of What Coun A	try?	
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 N 3 □ Widowed 4 □ Divord	Armed F 1 ☐ Yes If Yes, G Year or I	2 🔀 No ive Dates:	16a. Decedo	an Indian, etc. Le Justry						
er than "n the Medi	Completed	Elementary/Secondary (0-12	thest grade completed; College ((1-4or 5+)	Give kind of work done during most of working life. DO NOT use retired) Homemaker						Home	
irked othe	To Be (17. Father's Name (First, Midd James W. Ca					18. Mother's Nar Louise		, Maiden Surr	name)		
n 27 Is ma ier trauma	19a. Informant's Name/Relationship (Type. Print) Benjamin L. Dozier/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12246 Roundwood Rd, Timonium MD 21093											
ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【 Crematic 4 ☐ Donation 5 ☐ Other	(Cnapifu)	State Bav	emetery, crem View Ci	ition (Name of atory or other place rematory		Date 0/2008		n - City or To	_{wn, State} aryland	
any inj once.	21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230											
sician edical miner		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	ist only one cause on EN	caused the death each line. DSTAG (or as a consequence)	Do not ente	r the mode of dyir		or respiratory a	rrest,		Approximate Interval Between Onset and Death	
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
y the attending packed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐Live	itcome pf pregna birth 2 □ Feta nant at time of d nown	I death 3□I	Ectopic pregnancy Other <i>(specify)</i>		Date of delive Month	ry Day Year			
n signed b		Part II. Other significant cond	Itions contributing to a			derlying cause giv	en in Part I.	23e. Did t			e cause of death? ably 4 □Unknown	
cate has bee	Completed by	DECUBITE		e_				24a. Was auto perfo 1∐ Yes		prior to con death?	osy findings available npletion of cause of 2 No	
s certifi director	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpatient	3 □ DOA Oth		ath (Check only o	one) dence 6 □0	Dil /0 /6	4	
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at Directo	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rmined Zot. Flace	e of injury - At ho ling, etc. <i>(Specif</i>)	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rura	l Route Number,	
the Funer	Medical	(Check only 2 TMedic one)		e best of my kno- pasis of examina nner stated.	wledge, death tion and/or inv	estigation, in my o	ppinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. the cause(s)	
₽ 5 (2	29b. Signature and title of cert	LRR RR	relle	25	29c. Licens	e number 2-564	3	29d. Date sig	oned (Month, l	Day, Year)	
U		30. Name and address of pers Wendell R F	aulkner	se of death (Item	23a) (Type, P	charles	St Su	ite 209	/Bal	toni	21204	
Sta Registra		31. Date filed (Month, Pay Ye.	0 5 2008	Registra/s Signa	B.	barles						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 31, ^D2008 **Physician** Douglass Sr. 7:00P M Robert Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore 3849 Quarry Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. March 10,1927 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1**¥** M 2□ F Months Days 219-22-2440 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medical Experience must be redified at 10a. State 10b. County XXYes 2 □ No Baltimore Maryland N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 3849 Quarry Avenue Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1>XX*ges 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 212No Specify: Specify: δ 3 Widowed 4 Divorced White WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sugar Manufacturing Maintenance Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Douglass Herbert Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Buttrick Court, Timonium, Maryland 21093 Department of Health a Important: If item 27 is any Injury or other trainsnee. Daughter Linda Douglass 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/2008 Eldersburg, Maryland 4 Donatiση 5 DOther (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falis Road, Baltimore, Maryland 21. Signatury of Funeral Service Lic-21211 Approximate Interval Between Onset and Death 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myscar /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown - UNKnown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? renside autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred I or Attending Fafter death. 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🔲 No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 33220 MI 30. Name and address of son who completed dause of death (Item 23a) (Type, Print) Baltimore, MD 21211 3730 -ALLS () 5 Registrar's Signature 31. Date filed (Month, Day, State AUG 0 Registrar

			For State Registrar	State of M	aryland / D	epartm Certific	ent of I	Health and M Death	lental Hy	gien Reg. N	^e 2008	3 25040
	Physici /Medic		1. Decedent's Name (First, Middle, Las Irene Gladys F	•					2. Date of D Month AUGUS	Da	ay Year 2 200	
	Examin Funeral Director		4a. Facility Name (If not institution, give SAINT AGNES & 5. Social Security Number 6. S 1	OSPLTA ex 7. Ac	ge (In yrs. last birtl		BA1			irth	N/A	
	the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number		10c. City, Town	ltim	ore				itizen of What C	10d. Inside City Limits 1X Yes 2 □ No
9	after death with or items 23a or nitret must be a	Funeral Director	3118 Wolcott Av 11. Marital Status 1 □ Never Married 2 □ Married	Jenue 12. Was Decedent Armed Forces? 1		13. Was D If Yes,	21216	Hispanic Origin? (Sp van, Mexican, Puerto	ecify Yes or N Rican, etc.)	USA		erican Indian, te, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a firedical Examination to other traumatic event, if a firedical Examination of the resilies of once.	Completed by	3 □ Midowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 9th grade	Year or Dates:	16a.	Decedent's (Give kind o life. DO NO	Usual Occup	pation during most of work	ing		Kind of Business	
Maryland 2	uld be filed fental Hygi rked other ilc event, II	To Be Co	17. Father's Name (First, Middle, Last) Russell Bates					18. Mother's Name Janice	First, Middle Tayloi	e, Maidei	n Surname)	
, Mary	and 2 shou ealth and M n 27 is mai er traumai		19a. Informant's Name/Relationship (19b.	Mailing Add	ress (Street Longv	and Number or Run	al Route Num eet Ba	ber, City alti	or Town, State, More, M	Zip Code) 21216 Maryland
Baltimore,	. Pages 1 Iment of Ho tant: If iten jury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of cemetery King M	Memor	ial E	Park "		Woo	•	Maryland
Bali	permit Depar Impor any in	-	21. Signature of Fuheral Service-Licen	ris		5240	Reis	sterstow	n Rd I	Balt	is Fun imore,	eral Home Md 21215
	Physician /Medical		23a. Parl: Enter the Mease, or compose, or hear failure. List only disease or condition resulting in death)	a		SEP				arrest,		Approximate Interval Between Onset and Death HOURS
	Examiner	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of a consequence of	MA7	COSL	s INTO	ESTI	VAL	_15	HOURS
68760,	flicate be executed g physician and is the burial-transit	cal		d	a consequence of	i): 						
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/R Vita	Physician: r this certificatal director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ 00	Hospital:	ent 2 ER/Out	nationt 3	T DOA Oth	26. Place of Death ner: 4 \sum Nursing Ho			€ ∏Othor (C+	if - i
ρ_{S} ision of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Peath 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	ary 28b. Ti ny, Year) In	ime of jury M	28c. Inju Wor 1 🗀	ry at rk?]Yes 2 □ No	28d. Describe	how inju	ry occurred	
EP DIVI	Hospital or At 24 hours after d Funeral Direct tely filled in by		4 Homicide determined	building, et	ury - At home, farr c. (Specify)				City or To	wn, Stat	e)	lural Route Number,
	the Hosp hin 24 hor the Fune upletely f	Medical	29a. Certifier (Check only one) Certifying Ph 2	ysician: To the best liner: On the basis of and manner st	of examination and	death occu I/or investiga	rred at the ti ation, in my	ime, date and place, opinion, death occur	and due to th red at the time	e cause(, date an	s) and manner and place, and du	as stated. e to the cause(s)
	To th withir comp	Me	29b. Signature and title of castifier	Son	NO		29c. Licens	se number			ate signed (Mon	th, Day, Year)

State Registrar

BALTIMORE MD 21228

AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 25041 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:00A M Flichman Mildred 2008 August 1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 3821 Roland Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕇 F Months Days Hours Yrs. Sept 21, 1922 Director 216-12-6854 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any lojury or other traumatic event, if a Medical Examination in any logue. ¥XYes 2□No N/A Baltimore Maryland Directo 10f. Zip Code 21 21 1 10g. Citizen of What Country? 10e. Street and Number 3821 Roland Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify. Specify: <u>چ</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Reserve Bank Adjustment Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Kelbaugh Mildred Kirby ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven Flichman 1408 Weldon Place South, Baltimore, MD 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 8/6/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 Funeral Service Lig 21. Signature 3631 Falls Road. Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Examiner Chronic Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by related Gastritis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2 s autopsy performed? 1 □ Yes 2 🗷 No 2□No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 296. Signature and title of pertifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

DONE !

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Schwartz

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 10:24PM July 31, Thomas Maynard Fling /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You July 21, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1 X M 2 □ F 1949 Maryland 59 Director 214-48-6005 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Tra Medical Exondrat must be notified at 1 ☐ Yes 2 No Director MD Montgomery Burtonsville the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with U.S.A. 20866 3420 Greencastle Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Government Auto Mechanic 2 should be filed wind and Mental Hygier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Haslup George Washington Fling, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is many injury or who 19a. Informant's Name/Relationship (Type. Print) 116 Farmgate Lane, Silver Spring, MD 20905 George W. Fling, Jr. /brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery Aug 4, 08 Burtonsville, MD Union 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses H 313 Talbott Ave. Laurel, MAryland 20707-4389 Llu M00773 Approximate Interval Between Onset and Death 23a. Part 1. Enter the is 32 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** minutes Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. ned by the a 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ∏ Yes 2 ∏ No cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛚 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a

completely within 2 To the I

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

William A. Warren, M.D. 321 Prince George St. Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c Licesse number

29d. Date signed (Month, Day, Year)

August 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year ALI FARZAD /Medical 4, 2008 7.23 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months . Days Min 1**X** M 2□ F 84 Director 213-29-7784 1924 Iran Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits t be notified at show Director 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must b 3902 Link Avenue by Funeral 21236 Iran 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner i Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 😾 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7 years Parking Garage Proprietor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Asadallah Farzad ည Fahtemeh unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nader Farzad (son) 3902 Link Avenue Baltimore, Maryland 21236 20a. Method of Disposition Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 8-6-08 Timonium, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition DAresulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): the burial Box 68760. the attending physician Physician/Medical as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for Month Day Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has e 2 autopsy performed? 1∐ Yes 2 ☑ No page certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director completely filled in by the 6 ☐ Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after Hospital 1 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. S.RAO. M.O. D43462

State Registra

31. Date filed (Month, Day, Year)

GTOI NORTH CHARLES

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2008

32 Aegistrar's Signature CENTRAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 < 5 - 12 P C - 17 P C -

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1 OK my

31. Date filed (Month, Day, Year)

30. Name and address of person

Jack Titus MD.

Deputy Chief Medical Examiner

Year) 32 Registrar's Signature

who completed cause of death (Item 23a)

r's Signature

OCME

August 3, 2008

Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 5:40 P M 2008 July 29, Physician Genovese 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Birthplace (State or Foreign Country) Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Months Days Hours **Funeral** 1911 Italy 1 □ M 2 💢 F July 26, 97 335-03-9064 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10h. County 1 ☐ Yes 2 X No Director Timonium Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 98 E. Padonia Road, apt. 103 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Own Home Elementary/Secondary (0-12) Homemaker n/a 08 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Cosimini Fine Damiani Aurelio ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 148 Hollow Brook Road, Timonium, Maryland August Bruha/Son-in-law 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Aug 6, 2008 Hillside, Illinois Carmel Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 21. Signature of Fune at Service Licenses

Bryan W. Clary 10 W. Padonia Road, Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1 Interit e disease, or complication that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shore, or heart failure. List only one cause on each line. YEARS Immedia e Cause / Final disease v condit n resulting in a ath) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): physician all streets the burial-t P.O. Box 68760 Physician/Medical attending 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death IF FEMALE: Year 23b. Was decedent pregnant Month 3 Fctopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown þ Division of Vital Records, 1 ☐ Yes The law requires page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No peen 24a. Was an autopsy performed? Yes 2 No has 1 TYes this certificate 26. Place of Death (Check only one) Physician: 25. Was case referred to medical examiner? funeral director, Be HOSFICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Injury or Attending 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST, SUITE 209 BALTMERE, MD 21204 DOBERMAN, MO DANIEUT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28b,28d,28f,perME, G883 9/16/08 TT State of Maryland / Department of Health and Mental Hygiene Amend Items 4a,28a-f per meg.282,08/05/08dhb Reg. No 2008 25046 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 6:05P M Glas Franklin John June 24 /Medical 4c. County of Death Facility Name (If not institution, give street and number)

Washington County Hospital

N.S. Realtheare Hager 4b. City, Town, or Location of Death Examine Washington Hagerstown 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F 67 July 1, 1940 216-36-1829 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21704 U.S.A. 4550 Urbana Pike Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. Glas Margaret V. Holley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Annabel Avenue Baltimore, MD 21225 Miss Rebecca A. Glas/Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. June 28, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2008 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Asphyxiation **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 20 No)ementin or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ■ ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 1 🔲 Inpatient 28b. Time of **unk** 28c. Injury at Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 06/24/2008 Choking on food 5:00p. 1 ☐ Yes 2X No 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number of Bural Boyle Number, 140 Mgr Town, State) NMS Health Care Marsh Pike, Hagerstown, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Nursing Home To the Hospital within 24 hours a To the Funeral [16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 D0056965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSHED Stephen FARID 12 D 31. Date filed (Month, Day, Year) State 2008 AUG 0 5 Registrar

	1 - For State Registrar	ate of Maryland / Depa <i>Cer</i>	rtment of Health and l tificate of Death	Mental Hygien	- 200 2 LOT. 7
Physician	1. Decedent's Name (First, Middle, Last)	SLAY		2. Date of Death	ay Year S. Time of Death
/Medical Examiner Funeral Director	4a. Facility Name (If not institution, give street 17015 £ ring) St., Social Security Number 214–56–7543 6. Sex	t and number) Apr E 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Baltimere If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	1	c. County of Death 9. Birthplace (State or Foreign Country)
70	Usual Residence of Decedent 10a. State 10b. County Md • N/A	10c. City, Town or Loc Balt:		12 002 002 7	10d. Inside City Limits 1 ⊠Yes 2 □ No
fire death with the Mar fire sa or 28a-f st fire rust be notified Funeral Director	10e. Street and Number 1701 South Elrino S		10f. Zip Code 21224		USA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Eventual that the multibed at once. To Be Completed by Funeral Director		YTYes 2 □ No	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl ☐Yes 2 No Specify:	ipecity Yes of No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-003 ed within 72 hours a ygiene. ser than "natural", c t, the "n dical Eva Completed by	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12) 12 Years	college (1-4or 5+) (Give In life. D	ent's Usual Occupation kind of work done during most of wol O NOT use retired) Detmetalist		Kind of Business/Industry Steel
Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hydiene. Important; If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Eventions. To Be Completed by F	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maide Unknown	n Surname)
h, Mar and 2 sho ealth and n 27 is m ner traum	19a. Informant's Name/Relationship (Type. F Rebecca Hallock D	aughter 7557	Address (Street and Number or Rives Lane, Dunda	ılk Maryland	1 21222
timore it. Pages 1 rtment of H rtant; If iter	20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Remo	Bayview		st 5, Bal	Location - City or Town, State
Balperm Derm Department once	21. Signature of Funeral Service (Censee	ons that caused the death. Do not enter	onnelly Funeral H 10 Sollers Point	Road, Dunc	dalk P.A. dalk MD. 21222 Approximate Interval Between
Physician /Medical	shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	A		Onset and Death 6 years
ficate be execute by physician and stree burial-transit and edical Examiner		Hyperlipiden Lue to (or as a consequence of):	Ira		8 years
Box (Bot (Bath certification) Bot use a for use a for use a	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, F juires that n signed to ald be deta	Part II. Other significant conditions contributions Congressive H	uting to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes	o use contribute to the cause of death? 2 □ No 3 🏋 Probably 4 □ Unknown
Division of Vital Records, alor attending Physician: The law requires the after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be destriffication: To Be Completed by	COPD Chronic Kid	ney Disease	· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performed? 1 □Yes 2 ☑	
of Vital F Physician: The this certificate al director, pag	25. Was case referred to medical examiner?	1 ☐ Inpatient 2 ☐ EH/Outpatien	t 3 ☐ DOA Other: 4 ☐ Nursing I	ath (Check only one) Home 5 Aesidence	6 □Other (Specify)
Division of tall or Attending Physical after death. al Director: After this led in by the funeral dir Certification: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	8a. Date of Injury (Month, Day, Year) 8b. Time of Injury 8c. Place of Injury - At home, farm, stre	28c. Injury at Work? M 1 □ Yes 2 □ No set, factory, office	28d. Describe how inj	jury occurred and Number or Rural Route Number,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the de within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physic		building, etc. (Specify) In: To the best of my knowledge, death On the basis of examination and/or in	occurred at the time, date and place	City or Town, Sta	e(s) and manner as stated.
To the Hosp within 24 hou. To the Fune completely fil	29b. Signature and title of certifier	and manner stated.	29c. License number D Ø Ø 55698	29d. [Date signed (Month, Day, Year)
3	30. Name and address of person who complete Sundyon Jong M.D.			ore, MD 21	201
State Registrar	31. Date filed (Month, Day, Year) ALIG 0 5 2008	32 Registrar's Signature	all o		
DHMH 17 Rev 1/2001	1	ORIG	INAL		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25048 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Margaret Ε. Hartung Aug. 2, 2008 11:40a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days Months Min. 1□M 2**X**F 577-03-6234 94 Director 7/14/1914 Wash., D.C. Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Hyattsville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 804 Somerset Place 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: \$ Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Real Estate Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank F.Lewis Ethel E. Howell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20901 Charles F. Hartung/Son 10011 Brunett Avenue Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Chesapeake Crem 8/04/2008 Beltsville, Md 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of uneral Service Lice PATCIP ADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to thrive /Medical Due to (or as a consequence of) Examiner Gastro intestinal bleed Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Hyperthyroidism Due to (or as a consequence of): P.O. Box 68760, the attending physician Hypercalcemia Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page ; certificate 1∏ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient P 2 ER/Outpatient 3□ DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending Investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064539 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Srilatha Kanumuru MD 7300 VanDusen Rd Laurel, Md 20707

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 5

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year 9.00A EDNA G 2008 HOLBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 X F Director 96 579-50-9909 MARCH 18, 1912 NC Usual Residence of Decedent a or 28a-f show t be notified at 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 🛛 No LOUDOUN BLUEMONT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a dical Examiner must b 20149 WILLISVILLE ROAD 20135 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🎇 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 6th None permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumatic event, 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Flack Ida Carson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Turner / Daughter Bluemont, VA 20149 Willisville Road 20135 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Green Creek Cemetery | 08-09-2008 4 Donation 5 Dother (Specify) Polk County, NC 21. Signature of Euneral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in thine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last feilure The law requires that the death certificate be executed and Due to (or attending physician Physician/Medical If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only one) within 2

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

Fozia Abdulwahabe, MD. 8118 Good Lack Rd., Lankam, MD. 20106

29c. License number

D52500

29d. Date signed (Month, Day, Year)

07-31-08

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Anita Jean Hahn August 02 2008 11:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖫 F 75 Yrs. Oct. 215-28-4497 10 1932 Director MI Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examination man be rediffed at 1 ☐Yes 2X No Director Florida Charlotte Port Charlotte 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22295 Morris Avenue 33952 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be i Jeanette LaPointe Mooney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Hahn (spouse) 22295 Morris Avenue, Port Charlotte, FL 33952 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Uconsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Immediate Cause (Final Abdomnet **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and Due to (or as a consequence of) Physician/Medical the Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. þ Felure 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr certificate 2 No 2 No 1 Yes 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital hours Type Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Towsertown Bird/Balfoms Mare gistrar's Signature 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death

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Physician /Medical **Examiner**

Funeral

Director

death with the Maryland if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

ALTWICK

ed Iha

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Box 68760 signed by the a P.O. of Vital Records, cate has certificate this : After thi e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera Division To the Hospital within 24 hours a To the Funeral C completely filled in the completely filled in

3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 1227 KM HARTWICK REGINA 08 08 02 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2**X** F 67 7/30/1941 218-36-6800 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County MD **Baltimore** 1 No 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 USA 1434 Towson Street Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2▼ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 □XNo Specify. If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Accounting Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trene Smith John Deckret ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7828 C Street, Chesapeake Beach, MD 20732 Sharon Crow / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Bayview Crematory 08/06/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1SEMA INYERM EMPHU disease or condition resulting in death) Due to (or as a consequence of) BETES Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - ST BALTIMONE MD21225

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

32. Rep strar's Signature

State of Maryland / Department of Health and Mental Hygiene 25052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 30, 2008 **Physician** 11:27 PM MARY LEE HIMMER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD MORNINGSIDE ASSISTED LIVING ELLICOTT CITY 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 3, 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. Maryland 1 □ M 2 🔀 F Director 216-28-4111 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Mudical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City Howard Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2 USA 21042 5330 Dorsey Hall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced "naturaf" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Injury or other traumatic ပ္ Edison Lee Wallis Mary Byer Epperley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health au Important; If Item 27 Is any Injury or other trauonce. Karen Himmer Becker / Daughter 2942 Excelsior Springs Ct., Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Zion U.M.C. Cem.: 8-4-08 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD

23a. Part I. Enter the dis. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Altero Sclero Tic Cardio Vancular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Advanced Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) ASSISTED 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVING 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

**Record of the filled in by the filled in the filled death. 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N30641 August 1 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabape Thi 201-109 BackRiver Neck Road Balhmore Mouling 201-109 32. Registrar's Signature

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DHMH 17 Rev 1/2001

State

Registrar

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Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year KOSELLA 5:00 PM **ゴリレ**ソ 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours 1 ☐ M 2 😿 F 216-28-9848 SEPT. 20, 1933 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State BALTIMORE 1 Yes 2 No MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SOUARE U.S.A 2122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CROWDER GRACE ROSEVELT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1361 PENTRIDGE RD, BALTIMORE, MD 21839 GARLAND WHITE GON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST CEM. 08-08-2008 CWINGS MILLS, MARKAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
505EPH H. BROWN JR. FLNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MSSA SEPTIC BACTEREMIA disease or condition resulting in death) Due to (or as a consequence of) METABOLIC RENAL FAILURE Due to (or as a consequence of) ISCHEMIC 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) itions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No. 3 Probably 4 Unknown AMPUTATION, CONGESTIVE 1 🗌 Yes HYPERTENSION, DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy LEFT 1 ☐ Yes 2 ☐ No LOWER EXTREMITY 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

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Jo the Funeral Director: A completely filled in by the fi

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To the Hospital

funeral

page certificate

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Certification: To

Medical

State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23a

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Department of Health at Important: If Item 27 is any injury or other trau

Pages 1

requires that the death certificate be execute

Box 68760,

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Division of Vital Records,

2 should be filed within and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

other traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
by Ph	Part II. Other significant cond
Completed by	HEART FAILU
Com	TYPEIL, LEF

TYPEII

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural

6 ☐ Could not be

determined

2 Accident

4 | Homicide

3 Suicide

Inpatient 5 Pending investigation

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALTIMORE, MD

29b. Signatura and title of centifier

M.D.

29c. License number RES - 0001 29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET HANEEN

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 310e, 19b, per INF, G882, 8/12/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O 7 29 **Physician** HARC IIAM M DIAMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
ALICE MANOTHURSING 2095 4b. City, Town, or Location of Death **Examiner** ROCK RUSC N lΑ Baltimore Maryland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Mar. 7, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Maryland Months 1 ☐ M 2 🕱 F 220-12-7768 1925 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XXYes 2 □ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number dirard 21211 Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paolo Letra Lucia Valoro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2008 Cerard Melvin Hare Husband -Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Crestlawn Memorial 8/1/2008 Sykesville, Maryland 4 ☐ Donation / □ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service License 21211 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): vsician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Examine law requires that the death certificate be executed ment and as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the burial Piabele Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Joint 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31464 04 mi) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 221 N. ENTAW STENIE 30& BALTIMORE MID A HASHMIMD, Sto A113 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 0 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25055 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2:00 PM Physician CLIFFORD HOLLDAY 2003 MICHAEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 1**X**M 2□F Months Days 366-58-9103 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location or 28a-f show notified at 10a. State 1 Yes 2 No ESSEX **Funeral Director** BALTIMORE MD10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö Items 23a or ner must be n aidal USA roxcrott 1015 12. Was Decedent Ever in U.S. Armed Forces?
11 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: white. <u>چ</u> 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Medical Elementary/Secondary (0-12) College (1-4 or 5+) ManageR count 12 INSURANCE 5 t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F 27 Is marked of traumatic ever larv ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarkston, MI 48346 HORD 2500 Mann Koad # 425 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State 5 Department of Important: If any Injury or once. Moreland Mem Kark 4 ☐ Donation 5 ☐ Other (Specify) PARKVICLE. 22. Name and Address of Facility RD RD., PARKVILLE, MD 21234 21. Signature of Funeral Service Lieenses Evans Francial Chapolic Clemation Service Packy Ne locations that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest,

Approximate 23a. Prit 1. Enter the dise shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days Due to (or as a consequence of): G. hemorrage disease or condition resulting in death) /Medical **Examiner** lo years arrhosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) 6-7 year The law requires that the death certificate be executed Hennhs C ding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 10 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an bacteria pen toputs page 2 autopsy certificate has perfò No 1 🗌 Yes director, 25. Was case referred to medical Was case . examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 1 Apatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturai 2 ☐ Accident 5 Pending investigation Injury 1 🗌 Yes 2 No death. after death Director: / filled in by the Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours pertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou To the Funel completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi RES-000

State Registrar

JULIA 31. Date filed (Month, Day, Year)

MARSH mD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29, **Physician** July 2008 3:05 MAGDALENE L. HARDISON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 8908 Horton Road Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug 12, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months North Carolina Days Hours Min 1□ M 2√X 244-48-7233 90 1917 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it e Medical Examiner must be notified at 1 □Yes 2□No MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20708 U.S.A. 8908 Horton Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Who Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 If Yes, Give Year or Dates Specify. Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, It e IN once. College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtie Gattis John Henry Lawrence ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) granddaughter 8908 Horton Road Laurel, Maryland Catherine Hopkins 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State MD National Mem Pk. 8/4/2008 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 M00770 Approximate Interval Between 23a. Part 1. Enter the disease, o complications that shock, or heart failure. List only one cause of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it are the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physlcian: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending properties of the second 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregpant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 ANO 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation nours after death. neral Director: Af illed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie 30. Name and address of person who

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0

32. Registrar's Signature

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARY E. SPITZNANGLE'

20c. Location - City or Town, State

#109 BALTIMONE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 WEST MOSHER ST. BALTO., MD. 21217.

Date

GREEN MOUNT MAUS. 08/6/2008 BALTO CITY, MD.

22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111.

Physician /Medical

Funeral

Director

in than "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if term 27 ie marked other than "naturel", or item eny injury or other traumatic event, the Medical Exeminar's DRCS.

2

JOHN J. KING

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

JAMES L. BROWN (NEPHEW)

1 Burial 2 □ Cremation 3 □ Removal from State

dul

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

death with the Maryland

Examiner

attending physician for use as the burial detached à cate has been signed page 2 should be det certificate has been director,

physician and the burial-transit be executed or Attending Physician: the funeral s after death. filled in by within 24 hours after To the Funaral Dire To the Hospital

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical 26. Placs of Death Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0060560

BACK RIVER NECK PS.

DHMH 17 Rev 1/2001

State

Registrar

completed cause of death (Item 23a) (Type, Print)

201

32. Ragistrar's Signature

TERM

CHE

AUG 0

31. Date filed (Modth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 200<u>8</u> JULY 31, **Physician** 8;00p M MARY F. HAMMOND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A GOOD SAMARITAN NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 4-4-1906 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Months Hours 1 □ M 2 1 F MARYLAND 102 217-20-5563 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exterine must be notified at 1 √Yes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 510 ARLINGTON AVE. 21217 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK 2 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Menial Hygiene Important: If item 27 is marked other than any injury or other traumatic event, Item once. College (1-4or 5+) Elementary/Secondary (0-12) HOUSEKEEPING DOMESTIC -6-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NETTIE AMBUSH TONY HOWARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 714 KENNEDY ST. NE WASHINGTON, DC 20011 LEO R. WILLIAMS (NEPHEW) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation √3 □ Removal from State BALTIMORE NATIONAL 8-8-2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) WATHAN. D. HIB ER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Ace see 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease Condition **Physician** disease * condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1100011 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed ndre physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) P.O. ed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral dire Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun-1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D 31464 811108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEWTAW ST Anto 308 BOLTIMORE MD SHDAIB A 611) 821 IMPIETA! 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG Registrar

		State of Maryland / Department of Health and Mental 1 - State Registrar State of Maryland / Department of Health and Mental Certificate of Death	Hygiene Reg. No. 2008 25059
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Baltimo permit. Page Department o	Injury	4 Donation 5 Other (Specify) GARRISON FOREST 108/07/08 21. Signature of Funding Service Licensee 22. Name and Address of Facility	OWINGS MILLS, MARYLAND
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3 とんイ 人 . I Records, P.O. Box 68760, 人 The law requires that the death certificate be executed ate has been signed by the attending physician and	se as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9	, 23d. Date of delivery
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11:22p July 30 2008 JOHNSON ROSE CHRISTINA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARBORSIDE HEALTHCARE HARFORD N/ABALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Months Days 1 □ M 2**X** F MARYLAND NOV. 9 1948 214-50-7063 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XXYes 2 □ No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 518 N CAREY STREET 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2KXNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE BAR MAID 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERTA CHASE ELRICH JOHNSON ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lanham, Md. 20706 Samantha Brown/Daughter 9206 Morley Rd, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT ZION CEMETERY 08-09-08 LANSDOWNE, MARYLAND 21. Sign to e of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio Vancular Dil Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ NO 24a. Was an autopsy 1□ Yes 2 100 26. Place of Death (Check only one) 25. Was case referred to medica examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed physician and the burial-trans attending ph signed by the a been si has e 2 or Attending Physician: director, this

P.O. Box 68760.

Division or Vital Records,

Funeral

Director

28a-f show

or items 23a

ed other than "natural", event, the Medical Exa

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic.

Physician

/Medical

Maryland 21215-0036

Examiner must be notified

Examine Physician/Medical Completed by Be 2 After thi Certification: within 24 hours after death.

To the Funeral Director: completely filled in by the f

ical

Medi

27. Mann of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Back River Neck Road Baltimore Maryland 21221 201-109 Sabapalhi Ramesh

29c. License number

D 306 41

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Registrar

		1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h Day	Year	3. Time of Death	
hysicia! Medica/		Richard	Ka	ine			7	25	2008	<u> </u>	
Examine	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			nty of Death		
-		Rosewood State Ho 5. Social Security Number 6. Se	<u> </u>	t hirthday		s Mills If Under 24 Hrs.	8. Date of Birth		Baltin	nore	
neral rector			7. Age (111 yrs. las	Yrs.	Months Days	Hours Min.	May 22,	Year)	Col	yland	
A TI	-	10a. State 10b. County	10c. City, 7	Town or Lo	cation					10d. Inside City Limit	
event, I'm Medical Exacting Le Dullified at	ţō	MD Balti	more		Owings M	ills				1 ☐ Yes 2√€ N	
Paris .	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cou	untry?	
1815	ai D	200 Rosewood	Lane		21	117		U.	S.A.		
S S	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	rican Indian, e, etc.	
	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1		1 ☐ Yes 2 ☑ No	Specify:		Spe	icify:	White	
	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation during most of worki	00	16b. Kind o	f Business/I	ndustry	
4	pie.	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	1)	7,9				
	Completed	N/A			Unemp1o	J		N/A			
1	Be	17. Father's Name (First, Middle, Last)	77			18. Mother's Name					
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		_									
	(20a. Method of Disposition		e of Dispo	sition (Name of					27455 Town, State	
		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	-	natory`or other plac	Ser 7/28	/09 1	James at	ond	MD	
once.	-	21. Signature of Funeral Service Licens			2. Name and Addres		1824 Re:	Hampst			
ouc		Stophon	monken	2 EI	LINE FUNE	RAL HOME				21136	
+		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death.						(Approximate Interval Between	
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al		resulting in death)	Due to (or as a consequer	nce of):	/				-		
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-	ner	Sequentially list conditions, if a my, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecuer	nau of):							
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	<u>a</u>	Toodking in dodain, East	Due to (or as a consequer	ice oi).							
	edic		d								
3	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc					23d.	Date of deli	very	
-	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		Ectopic pregnancy Other (specify)	·			Month	Day Year	
	ysi	9 Unknown	9□ Unknown								
	by P	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	pacco use c	ontribute to	the cause of death?	
							1 🗆 Yı	es 215 No	3 □ Pro	obably 4 Unknow	
	Completed						24a. Was a	n 24	b. Were au	topsy findings availab completion of cause o	
	E				. <u>.</u>		perform	med? 2 Z No	death?		
	Be	25. Was case referred to medical				26. Place of Death					
- -	0	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 ☐ Reside	ence 6 🗷	Other (Spec	TCF. MI	
		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	Wor	k?	28d. Describe ho	ow injury oc	curred		
	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	-01 11 (0			ral Route Number,	
1	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		City or Town		1111001 OI AL	rai noute Number,	
		29a. Certifier TXCertifying Phy	sician: To the best of my knowle	adaa daat	h coourad at the tim	no, data and place	and due to the c	ausole) and	manner as	stated	
	edicai	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	pinion, death occurr	ed at the time, d	ate and plac	ce, and due	to the cause(s)	
	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date sig	gned (Month	n, Day, Year)	
		Double Licher	20		D29	275		7.25	2008	7	
	-		.111	3a) (Type.						S	
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
		Hr. Varathan I ULIVEV	MUSEULEU LENNEU	1	ic Kesewee	Q ~ Q ~ (4) (4)	Cours 1	VIIIS 1	(11/	2111	
State	e	Dr. Dorotheal Uckel 31. Date filed (Month, Day, Year) ALIC 0 5 2008	32. Registrar's Signatur	Assa.		a raye	cuing /	VIIIS	nr)	21111	

08-05922 Doris Jane Kolb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar Certificate			_{2.No.} 2008 2506
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Examir		DOLLE DAME NOTE		August 2, 2	2008
		Facility Name (if not institution, give street and number) 8044 Lansdale Road	4b. City, Town, or Location of Baltimore	f Death	4c. County of Death Baltimore County
Funcial	-	Social Security Number 6. Sex 7. Age (In yrs. last birthday)		24Hrs 19 Date of Birth	n(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		AF	Months Days Hours	Min. 02/01/	Foreign No 7
>	ļ	Usual Residence of Decedent			
w any		10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1 Yes 2 X No
Aaryland 28a-f show 1 at once.	햦	Maryland Baltimore Baltimore	10f. Zip Code	110	g. Citizen of What Country?
ith the Mar 23a or 28:	Director		21224		
with the s 23a e noti		8046 Lansdale Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever	Vas Decedent of Hispanic Orig		Inited States 14. Race - American Indian, Black,
death r	Funeral		f Yes, specify Cuban, Mexican,		White, etc.
after	질		Yes 2 X No specify:		Specify: White
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Deceded during	ent's Usual Occupation (Give a most of working life. DO NOT		16b. Kind of Business/Industry
36 in 72 than	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)			Domontio
-00 d with	5	9 Homes 17. Father's Name (First, Middle, Last)	maker	s Name (First, Middle, M	Domestic Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	James Yeider	Norm	a Dingus	ŕ
221 nould is mai	٩		ling Address (Street and Num	ber or Rural Route Num	ber, City or Town, State, Zip Code)
MD nd 2 shc alth and m 27 is aumati					Maryland 21224
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or		Date	20c. Location - City or Town, State
tim trent trant:	ļ	Deficition of Guide Specify.	Crematory		Baltimore, Maryland
Baltimore, MD 21215-0036 251215 2512 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	l	21. Signature of Funeral Service License.	Name and Address of Facility avid J. Weber	Funeral_Hom	nes P.A.
Physician	-	28a. Part I. Enter the disease, or complications that caused the death. Do not enter	OT S. Chester or the mode of dying, such as c	Street Balt ardiac or respiratory arre	cimore, Maryland 21231 est, shock, or heart Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone & alprazo.	lam intoxicati	on	Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):	Idd Inconteger	OH	
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Cuise Etter II 3 right g Causa (Disease or injury that initiated			
ed sit	Exai	events resulting in death) Last Due to (or as a consequence of):			
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed sath. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDED AMENDED 23a,PII,27,28	Ba-f. nerME. ø	882 8/27/08	тт
760, icate be physicia the buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	T, Perim, 8		23d. Date of delivery
687 certifice ading p		23h Was decaded assessed in the	Fetal death 3 Ectopic	pregnancy	Month Day Year
Box 687 e death certific the attending ed for use as t	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)		1
D. B t the de by the	된	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pa	rt I. 23e. Did to	bacco use contribute to the cause of death?
ires that the signed by I be detach	a p	Cocaine use		1 Yes	2 No 3 Probably 4 V Unknown
of Vital Records, of Physician: The law requiremental file this certificate has been some and director, page 2 should I	Completed by			24a. Was a	
Reco The law icate has	dmo			autop: perfor	med? death?
tal Rec		25. Was case referred to medical	26.Place of Death		z no i v ies z no
Vital I ysician: his certifi director,	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	[Othor:		Residence 6 🗸 Other: Scene
X 1 of Vi ling Physi After this funeral dir		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Month, Day Year)	of Injury 28c. Injury at Work	? 28d. Describe h	now injury occurred
	aţie	Natural 5 Pending Pending Prod 8/2/08 Fnd 4	:30pm 1 Yes 2 X	No unk	
Division pital or Attendio ours after death. teral Director: A	Certification:	3 Suicide 6X Could not be determined (Specify) 4t house	treet, factory, office building, et	_ or Town, S	Street and Number or Rural Route Number, City tate) 8044 Lansdale Rd
Divis Hospital or A 24 hours after Funeral Dire	- 1	4 Homicide (Specify)		Baltimo	
Divis To the Hospital or At within 24 hours after dr To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner: On the basis of examination and/or investi			
To William	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		James Twithall mi	O.C.M.E.		August 3, 2008
		30. Name and eddess of person who completed cause of death (Item 23a)		_	I
			111 Penn Street, Baltim	ore, MD 21201	
St Regist		31. Date filed (Month, Day, Year) AUG U 3 32. Registrar's Signature	de la		
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00115 0000		ORIGIN	1/1L		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25063 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 2008 Year AUGUST 8:45A M KOSTOVETSKY MANYA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A SINAI HOSPITAL OF BALTIMORE 9. Birthplace (State or Foreign Country)
RUSSIA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/25/1921 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days Months 87 220-11-2740 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1X Yes 2 □ No BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3601 FORDS LANE, APT. 701 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RAACHLIN RACHIL **EPSHTEIN** ABRAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POINSETTIA COURT, BALTIMORE, MD 21209 LINA TEFERI / DAUGHTER 20b. Place of Disposition (Name of competery, promatery of other place)
CHIZUK AMUNO CONG. 08/04/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of) hio Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

> and burial-trar

the attending physician hed for use as the burial

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neral Director: After this
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To the within 2

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page 2 certificate

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,<

P.O.

Division of Vital Records,

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once.

Physician

/Medical

Examiner

Directo

Funeral

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Physician/Medical

Completed by

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Certification: To

Medical

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ira Madical Examinar must be indiffed at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3640

32 Registrar's Signature

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

MD

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Fords 1

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

Dr. Rida Frayha

20157

ance Baltimore

08-03-08

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar			,,	Certific	cate of	Death		Reg. No.	2008	25064
	Physici	an	1. Decedent's Name	(First, Middle, Las	st)	L	ENT			2. Date of De Month	Day	Year 2003	3. Time of Death
7	/Medio		4a. Facility Name (III	not institution, give	e street and number)			City, Town, o	or Location of Death	2014	3 \ 4c.	County of Death	
			ZINAI			14 MER		a Ity	If Under 24 Hrs.	147		NH	nplace (State or Foreign
	Funeral Director		5. Social Security No. 218-43 Usual Residence of	4500	ex	e (In yrs. last b		nths Days		8. Date of Bi Month, D		945 9. Birti	iprace (State or Foreign intry)
	yland how		10a. State	10b. County		10c. City, Tov							10d. Inside City Limits
;	ne Mar 18a-fs	Director	Md.	N	19	/3H	2121		5				1 XYes 2 □ No
	ath with the 23a or 2	ral Dir	10e, Street and Nun	W. a	O ALKISON	AVE	-		1215			zen of What Cou	· ·
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If I them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Exariant round be indiffed at	by Funeral	11. Marital Status 1 □ Never Marrie 3 □ Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Decedent of long specify Cubes 2 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
215-0036	2 hour	ted t		15. Decedent's Ed	lucation	168	a. Decedent's			tring	16b. Ki	nd of Business/I	
2	ithin 7	Completed	Elementary/Secon	ify only highest gra- ndary (0-12)	College (1-4or 5	+)	life. DO N	OT use retire	e during most of wor ed)	king 	27	TE OF	T MARYLAN TOCTAL SER.
d 21	filed w Hygie sther t		17. Father's Name (First, Middle, Last)	NIA		DOCE	ac i	18. Mother's Nan	ne (First, Middle	, Maiden	 	arar sex.
/an	uld be Mental Irked c	To Be	Joe	= 1	AUZS				LENA	,	CH	MELE	5
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	Hospita 4 hours Funeral tely fille	Medical C	29a. Certifier (Check only one)	1 Certifying Ph	ysician: To the best niner: On the basis o and manner sta	f examination a	ge, death occi ind/or investig	urred at the lation, in my	time, date and place opinion, death occ	t e, and due to th urred at the time	e cause(s) and manner as d place, and due	s stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** August 2, 10:07 p M Murrill Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Baltimore Towson Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Davs Hours 218-26-4863 172 M 2 ☐ F 77 Director May 16, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show tre Medical Examination must be notified at 10a, State 10b. County Md. Baltimore 1 ☐ Yes 2√ No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7863 Kentley Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify Specify: White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Car Inspector Patapsco Rail Road 10 Years permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Seward Long Anna Margeret Stehr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Long Daughter 8505 Akron Road, Rosedale Maryland, 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 8, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dak Lawn Cemetery Dundalk, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) ature of Fungal Service Licens 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P 7110 Sollers Point Road, Dundalk, M P.A. Md. 21222 Approximate Interval Between Onset and Death 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. PROSTATE (**Physician** 10ans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4 Pregnant at time of death signed by the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only o Be examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPLOS 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred After t 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the rause(s) and manner stated. 29a, Certifie Medical (Check only one)

be executed Box 68760, certificate requires that the death o 0 Division of Vital Records,

72 hours after

Maryland 21215-0036

Baltimore,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ndal

AUG 0 5

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registra s Signature

29c. License number

rustrusur

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANCES B. LIVESEY 2008 Ju1y 30, 3:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 9, 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** Days Hours 1925 1 □ M 2 ☑ F 83 213-20-2568 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore County Baltimore 10f. Zip Code 10g. Citizen of What Country? 178 Brandon Road 21212 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hyclene, important: If Rem 27 is marked other than 'any injury or other traumatic event, the Me or Elementary/Secondary (0-12) College (1-4or 5+) <u>Legal Secretary</u> Law Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thomas Garrity Clara Louise Lowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Lowell Livesey (Son) 547 Rhapsody Court, Hunt Valley, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 8/5/2008 Baltimore, Maryland 21. Signature of Funeral Service Lie 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** gram negativ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physician and use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 D No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. M. n. of Death 1 & Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifie 29c. License питье

State Registrar 31. Date filed (Month, Day,

Pages

death certificate be executed

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

32. Regisfrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death dent's Name (First, Middle, Last) 2. Date of Death Physician 2:08pm 2008 /Medical 4c. County of Death 4b. City Town, or Location of Death ame (If not institution, give street and Examiner Birthplace (State or Foreign Country) (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X**M 2□ F 49 Director 212-76-2037 06/18/1959 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🙀 No Directo Gwynn Oak Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 U.S.A. 1454 Langford Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 'natural", or items 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event, It. If item once. Elementary/Secondary (0-12) College (1-4or 5+) Odd Jobs Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Mae Atkinson မ Amos Mason Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1454 Langford Road, Gwynn Oak, Maryland 21207 Joann Brown / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 08/09/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 To not enter the mode of dying, such as cardiac or respirator 23a. Part 1. Enter the disease or complicate shock, or heart failure. List only one can at caused the death. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner be executed Cause (Disease or Injur that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician the burial 68760. Physician/Medical The law requires that the death certificate attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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d in by the fur 2 No 1 TYes 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated 29d. Date signed (Month, Day, Year) 29b. Signatur

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Registrar's Signatur

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08-05917 Garry Miller

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 0 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 0 3 Probably 4 25. Was case referred to medical examiner? 1 Yes 2 No 0 Other; 4 Nursing Home 5 Residence 6 Other: Scene 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Number or Rural Route or Town, State) 1 Yes 2 No 2 No 2 Probably 4 Death of the cause given in Part II. 25. Was case referred to medical examiner? 1 Yes 2 No 2 No 3 Probably 4 Death of the cause given in Part II. 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 1 Yes 2 No 2 N	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Yes 2 No 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 0 3 Probably 4 24a. Was an autopsy performed? 1 Yes 2 No 0 3 Probably 4 25. Was case referred to medical examiner? 1 Yes 2 No 0 Other; 4 Nursing Home 5 Residence 6 Other: Scene 1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Number or Rural Route or Town, State) 1 Yes 2 No 2 No 2 Probably 4 Death of the cause given in Part II. 25. Was case referred to medical examiner? 1 Yes 2 No 2 No 3 Probably 4 Death of the cause given in Part II. 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 1 Yes 2 No 2 N	Teal
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Chronic alcohol abuse Chronic alcohol abuse Chron	
autopsy performed? Vest 2 No No No	
To the part of the	of cause of
25. Was case referred to medical examiner? 1 V Yes 2 No 25. Was case referred to medical examiner? 1 V Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 X Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Death (Check only one) 28d. Describe how injury occurred 28d.	No No
O CO TOWN, State) No	
Top Cheek only Top Cheek	
2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route or Town, State)	
determined (Specify) Suicide A Homicide A	Number, City
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
✓ 4 = 4 = 1 one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the basis of examination and/or investigation.	i
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, or particular to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, or particular to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	ear)
O.C.M.E. August 3, 2008	
30. Name and address of person who completed cause of death (Item 23a)	-
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) Registrar AUG 0 5 2008 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State	State	of Marylan	d / Depa	rtmen <i>tificat</i>	t of H	ealth and N	/lental F			08	250	169
			Registrar 1. Decedent's Name (First, Middle,	/ast)		Cei	uncan	OI L		2. Date of	Reg Death	. No.		3. Time of De	eath
	Physicia			MILLER						Month AUGUS	יחי כ	Day 2008	Year	6:45	η M
	/Medic		4a. Facility Name (If not institution,		umber)		4b. City,	Town, or	Location of Death	HUGUS) I	4c. County		0.43	A
	LXaiiiii		201 Crocker	Drive	Apt. A		Bel	Air				Harfo			
	Funeral			6. Sex 1 □ M 2 X F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of (Month,	Birth Day, Y			place (State or I ntry)	Foreign
Н	Director		234-32-5337 Usual Residence of Decedent		85	Yrs.				Feb.	26,	1923	Wes	t Virgi	nia
and	A ==		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	Limits
Mary	-f show	tor	Maryland Harfor	rd	I	Bel Ai	_							1 ¥Yes 2	. □ No
h the	or 28g	Directo	10e. Street and Number				10f. Zip	Code			10g	. Citizen of \	What Cou	ntry?	
th wit	23a c		201 Crocker D	rive	Apt. A		21	014_			1	UŞA			
G Z I Z I 3-0030 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, the Medical Examination into the modified at once.	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F	2 X No	1	Was Deced fYes, spec l □Yes	ify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or Rican, etc.)	No-		ck, White,	can Indian, etc.	
OUCO hours af	ural",	d by	3 XWidowed 4 □ Divorced	Year or							16	6b. Kind of B		White_	
22 1	"nat	Completed	15. Decedent (Specify only highes	t grade completed		16a. Deced (Give life, l	kind of wo DO NOT us	rk done d	luring most of work	king		D. KING OF D	usiiiess/ii	luustry	
with K	giene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homen	naker					Own H	iome_		
	othe vent,	Be C	17. Father's Name (First, Middle, I	_ast)					18. Mother's Nam	e (First, Mic	idie, Ma	iden Surnan	ne)		
	Menta arked	10 1	Thomas Rile	y Wilsor	1	,			Alberta	Lee	Sho	rt			
Saho	is mid		19a. Informant's Name/Relationsh						and Number or Ru				State, Z	ip Code)	
2 'e	Health		Phyllis R. King	/ Daugh					., Edgewo	ood, M		1040 oc. Location	- City or T	own State	
	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Gremation		n State I	Place of Dispo cemetery, crer							•		
Daltimor	artme ortant injury	5,000	4 ☐ Dohation 5 ☐ Othe (Sp. 21. Signed ure of Fun = 1 Service I	1 /	Be.i				Grdn 8-8- as of Facility				, Ma	ryland	
ם פ	Depa Impo any Ir	h 1)		-11		AcCom	as Fu	ss of Facility ineral Ho sbury Roa	ome,	P.A.	ion M	וזייבו	and 210	na
			23a. Part 1. Enter the disease, or	complications that	caused the deat								ary.	Approximate Interval Betw	
PI	hysician	S 1	shock, or heart failure. List Immediate Cause (Final disease or condition	-	Corona	in Ar	Long	Di	SPASP					Onset and De	eath ArS
ا ار	/Medical		resulting in death)		o (or as a conseq		1	-	301130					~ / ~	
E	xaminer	L	Sequentially list conditions,	b										-	
7 0	sit s	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse.)	uence of):									
XACIII	and al-trar	xan	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):									
20 2	siciar burit	dical E		đ											
الله و	ig phy as the	ledic													
. Box 58/50, \	t use	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		☐ Ectopic p	regnanc	v				ate of deli	,	ear
Б	s been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pre 9☐Un	egnant at time of o known		Other (s					IVI	Ontil	Day 16	, ai
7. ½	ed by detac		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying (ause give	en in Part I.	23e. l	Did toba	acco use con	tribute to	the cause of de	ath?
ecords, P.O.	n sign Id be	Completed by	Chronic	obstruc	HIVE P	ulmon	Ary	DIS	eASC.		1 ☐ Yes	2 □ No	3□ Pr	obabły 4 🗷 Ú	nknown
() -	s beel	lete					'				Was an		Were au	topsy findings a	vailable
ב ב	te has	mo								1 DY	entopsy	ed?	prior to death? 1 ☐ Yes	completion of ca 2 ☑No	use of
Vital	rtifica tor, p	0	25. Was case referred to medical	14		- 77-			26. Place of Dea				1 103	2 22110	
OT V	his ce I direc	To B	examiner? 1 Yes 2 No	Hospital: 1[Inpatient 2] ER/Outpatie	nt 3□D	Oth	er: 4 Nursing H	lome 5 <mark>∑</mark>	Resider	nce 6 □ Ot	her (Spe	cify)	
ם פ	After t unera	o	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	g (M	te of Injury onth, Day, Year)	28b. Time of Injury		28c. Injur Worl	k?	28d. Desc	ribe hov	v injury occu	rred		
SIO	tor: / the fi	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	2 000	no of laium. At h	ome form at	M		Yes 2 □ No	20f Locati	on /Str	not and Num	bor or Pi	ıral Route Numb	hor
Division Lor Attending	after of Direction by	Certification: To	4 ☐ Homicide determ	ined 28e. Fla	ce of Injury - At h ilding, etc. <i>(Speci</i>	ify)	reet, lactor	y, office		City o	r Town,	State)	ber or ni	irai noute Num	<i>i</i> ei,
_	in the transplant of whenting ringstrain, the tart within 24 burts after death. To the Funeral Directors After this certificate has completely filled in by the funeral director, page 2 s	alC		ng Physician: To t Examiner: On the											
d d	the Fit	ledical	one)	and m	anner stated.	adon and/of II				anevat (IIB)					
Ę	Con con	Σ	29b. Signature and title of certifie		.		29		se number		29			h, Day, Year)	
	4			an,		m 00-) /T-	Deic 4)		9763					4,200	
-	0		30. Name and address of person			m ∠3a) (1ype, 2∧1	2 7	Ile m	te Rd,	5te 11	12	Bei	Air	MD 21	015
	Sta	ate	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ature	. 10	110 1/1	1.00	J . O [(7	1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-, -
	Registi		AUG 0 5	2008	Bear .	Me A	2000 E								

DHMH 17 Rev 1/2001

08-05899 Hattie Mobley

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State of Maryland / Department of Health and Mental Hygiene

2008 25070

		1-For State Certificate of Death Reg. No.	2007						
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Hattie Belle Mobley 2. Date of Death Month Day Year August 1, 2008 3. Time of August 1, 2008							
	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1300 Lanvale Street Apt. 232 4c. County of Death Baltimore							
Funeral Director		5. Social Security Number 212-44-5601 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 4. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) Foreign Country)	S.C.						
v any		Tot. State	e City Limits						
Maryland 28a-f show	ţor	MD N/A Baltimore 10g. Citizen of What Country?	s 2 No						
the Mar a or 28s	Direc	1300 Lanvale Street Apt 232 21213 U.S.A.							
death with the Maryland or items 23a or 28a-f sho must be potified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,						
ifter dea il", or i	2	3 Widowed 4 Divorced If Yes 6 give Year 1 Yes 2 X No specify: Specify: Black							
hours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							
5-0036 lied within 72 hours after Hygiene. I other than "natural", the Medical Examiner.	Completed	12th grade N/A Nursing							
15-0 filed w al Hygie ed othe	To Be Cor	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Mobley Alice Wilson							
2121 ould be fil d Mental F s marked		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
ore, MD 2		LaShone Mobley-Daughter 4507 Fairview Avenue Balto, MD 21216							
MOFE Pages 1 ent of H int: If i		1 X Burial 2 Cremation 3 Removal from State King Memorial Pk 8-9-2008 Randallstown							
Balti Permit. Departm Imports		21 Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 2.	1202						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approxi	mate Interval						
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death						
		Sequentially list conditions, b.							
L ,	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated							
cuted and transit		events resulting in death) Last Due to (or as a consequence of): d.							
760, icate be executed sphysician and the burial - transit	Medical	UNPENDED AMENDED							
68760, certificate be ding physic	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Day	Year						
Box 687 he death certific the attending i		1 Yes 2 No 9 Unknown Unknown							
s, P.O. irres that the signed by t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4							
rds, requires been sig	So you was decembled by the past 12 months? 1								
Vital Records, hystein: The law requir this certificate has been s id director, page 2 should it	Completed	autopsy prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No						
ician:	Be C	25. Was case referred to medical examiner?							
n of Vir ding Physia After this funeral dir	1: To	1 Yes 2 No Impater 2 Erocupation 5 SA No Impater 2 Erocupation 5 S							
Division tal or Attendir rs after death. al Director: A	ation	Natural 5 Pending 1 Yes 2 No	Number City						
> 1 4 5 5 5	Medical Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route or Town, State)	Number, City						
the Hos nin 24 h the Fur		On Onlife and	s)						
To To corr		29b. Signature and title or centiner 29b. License number 29b. Signature and title or centiner 29b. License number 20b. License							
- H		RIPPLE for O.C.M.E. August 2, 2008							
OCME		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
S Regis		31. Date filed (Month, Day, Year) AUG 0 5 2008 32, Registrar's Signature							

Please Type an Print in Black Indelible lak. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2008 10 Aua 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner obial Security Number 0945 7. Age (In yrs. last birthday) sapeake toc the If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 12, 193 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 № M 2 🗆 F 219-34-027 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylan or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🗖 No Directo -d 00 W00 | 401. Zip Code MD tactors 10g. Citizen of What Country? 10e. Street and Number 21040 ited Fpp4de Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dennis Davidson Elementary/Secondary (0-12) College (1-4or 5+) Electrica 12 18. Mother's Name (First, Middle, Maiden Surname) Injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) Be Inelma permit. Pages 1 and 2 should Department of Health and Mer dna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Edgewood MD 21040 3107 Ebbtide Drive -ourse Mueller Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

20c. Lo Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MyoCarolla **Physician** disease or condition resulting in death) /Medical Due to (er as a consequence of): Examiner Corendon a Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physician and Due to (or as a consequence of) law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Ö 9 Unknown signed by σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? P Hospital or Attending P 24 hours after death.
Funeral Director: After t 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 13/2008 D0063220 GEORGE ISCUARMS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 0 5 Registrar

8003245Y

			For State Registrar	State of Maryla		rtificate of			Reg. No.	711110	25072
	Physicia		1. Decedent's Name (First, Middle, Last)				-	2. Date of De	ath Day	y <u>Ye</u> ar	3. Time of Death
	/Medic			С.	Meyer			July	31	2008	3,00A. M.
	Examin	er	4a. Facility Name (If not institution, give str Baltimore Washingt		Center		r Location of Death Burnie	•		County of Deat	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In)	90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 2			hplace (State or Foreign untry)
	ъ	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	1100	City, Town or Lo	cation					10d. Inside City Limits
	f shov		MD Anne Art		len Burr						1 ☐ Yes 2 🔯 No
21215-0036	r 28a-		10e. Street and Number	ilide1 G	Tell Dari	10f. Zip Code			10g. Cit	tizen of What Co	untry?
	th with		408 2nd Avenue SW			21061			U.S.	.A.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercites 1; ust be notified at once.		11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 □Yes 2∑No	dispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White Specify: Whi	e, etc.
	hin 72 hou e. an "natura Medical I		15. Decedent's Educa (Specify only highest grade	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Ki	ind of Business/	Industry
21	ed with ygiene ier tha t, th			4	Teacl	ner					lic Schools
Baltimore, Maryland	ntal H ed oth		17. Father's Name (First, Middle, Last) Robert E. Meyer				18. Mother's Nam			Surname)	
	should nd Me mark matic		19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailii	na Address (Street	and Number or Ru			or Town, State, 2	Zip Code)
	and 2 salth a		Mrs. Hope R. Meyer,		I	-	e SW Gler		-		
	Pages 1 annent of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of matory or other place lge Memor	i ž.	Date 4,		ocation - City or	•
Balt	permit. Departi Imports any Inji		21. Signature of Funeral Service Licenses	in nor			ess of Facility Sin 2nd Ave				Cremation e, MD 21061
E	Physician	al Examiner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line.	` ^	ter the mode of dyil	ng, such as cardiac	or respiratory a	errest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):						54000
			Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):						2 germ
	tificate be executed g physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury that initiated events as ultimated events.								
60,	be exician a		resulting in death) Last	Due to (or as a con-	sequence of):						
68760,	tificate ng phys as the	ledical	d.	-					1.0		
I Records, P.O. Box	death cer e attendir d for use	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су			23d. Date of de Month	livery Day Year
	that the		Part II. Other significant conditions conti	ributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e, Did t	tobacco	use contribute to	the cause of death?
	w requires that s been signed t should be deta	ed by						10	Yes 2	X No 3□ Pi	robably 4 ☐ Unknown
	: The law re cate has be page 2 sho	Completed						24a. Was auto perfo 1 Yes	psv	l prior to	utopsy findings available completion of cause of
		BeC	25. Was case referred to medical examiner?			1-:	26. Place of Dea				
0	gi se ie	Medical Certification: To I	1 ☐ Yes 2 No Ho	spital: 1 Inpatient 2 28a. Date of Injury	2 ER/Outpatie		4 ☐ Nursing H	ome 5 ☐ Resi		6 ☐ Other (Spe	cify)
on	ding F th. After funera		1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yea		Wor	k? Yes 2□No	Zou. Describe	now injui	ry occurred	
Division	To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral		3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	reet, factory, office		28f. Location (City or To	Street ar wn, State	nd Number or Ri e)	ural Route Number,
)	ne Hospit n 24 hours ne Funera bletely fille		29a. Certifier (Check only one) Certifying Physical Certifier Physical Certifier Physical Certifying Physical Certifier Physical Certifie	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, deat	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s , date an	s) and manner a d place, and due	s stated. e to the cause(s)
	To the withing To the comp	ME	29b. Signature and title of certifier			29c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Year)
	te		Posta		nd	D4	3977		Jul	1 31	2008
	12		30. Name and address of person who con	pleted cause of death ((Item 23a) (Type,	Print) LWR.	Glen Su	wme	·M	A 21	061.
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S	grature A	rate s			**		<u> </u>
	negisti	-1	At 10 0 5 211117	1 30 March 2 3	A. A. A.	D. C. L.					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 14:13 PM MCCLUSKEY JAMES JULY 31 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HARBUR HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 6 Sex Funeral Months Days Hours 1XM 2□ F 39 217-04-8649 August 22, 1968 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Harford Abingdon Maryland the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 510 Eastview Terrace 21009 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten ury or other thatmatic event, its Madeal Eventine ury or other traumatic event, its 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Self Employed Marine Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JoAnne Smiley Henrey William McCluskey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chantal McCluskey wife 510 Eastview Terrace Apt 7, Abingdon, MD. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State August 4, permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee onnelly Funeral Home Of 110 Sollers Point Road, dt 21222 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER Physician UNKNOWN resulting in death) /Medical Due to (or as a consequence of) Examiner UNKNOWN PNEUMOTHORAX Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence The law requires that the death certificate be executed Examir burial-tran Due to (or as a consequence of) physician the burial P.O. Box 68760, Physician/Medical attending properties for use as as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached to ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after death.
I Director: After this ce 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier within 24 houndless to the total the total Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 31 JULY 2008 RESOCO MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 STREET LEE 3001S. HANOVER 21225 KATE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 0 5

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene per Inf G882 8/14/08 TT Certificate of Death Reg. No. Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 3008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner N/A university of Mers timore 1701 Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Yea 12/05/19 **Funeral** Months Days 1**X**□M 2□ F WV 55 Director 235-82-3076 56 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar roust be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director COLUMBIA MD HOWARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 6024 CLOUDLAND COURT Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: Specify. <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) US GOVERNMENT PATENT EXAMINER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSEN **MILLER** BERNARD SYLVIA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 6024 CLOUDLAND COURT, COLUMBIA, MD JANICE MILLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMPLIAN
ATTZ CHAIM 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 08/03/2008 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) The law requires that the death certificate be executed Exam and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical F FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 aneurysm Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Hospital or Attending Natural 2 Accident (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as date and place. And due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2 person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

10

AUG

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 31, 2008 **Physician** 7:55A ELIZABETH MORRIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner None Baltimore 5937 Falkirk Road 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** 1 M XX North Carolina 100 219-16-9659 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at XXX Yes 2 No Director Baltimore Maryland None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 USA 5937 Falkirk Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23ant. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify: Baltimore, Maryland 21215-0036 Completed by ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Walston LaFavette Langley ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14018 Green Croft Lane Hunt Valley Maryland 21030 DTR Yvonne Mueller 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Hipportant: If ite any Injury or ot once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 4, 2008 Pikesville, Maryland Druid Rdige Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Sen 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease or complicati shock, or heart failure. List only one Immediate Cause (Final pertension **Physician** disease or condition resulting in death) /Medical Due to (r s a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 9∏Unknowr ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 100 Hearing 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) STANO Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Medical Certification: To this 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

p-12 Road Letheralle MD 21093

08-05816 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nancy Noell State of Maryland / Department of Health and Mental Hygiene 2008 25076 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examine Nancy Noell July 29, 2008 ETC. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Months Director Davs Hours Min 566-35-0182 М 2 x F Country) 04/28/1959 49 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show ; 23a or 28a-f show e notified at once. Maryland Frederick tes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5339 Carroll Boyer Road 21769 USA ē 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black. the Medical Examiner must be Armed Forces? White, etc. Never Married 2 x Married Yes 匝 Widowed If Yes, Give Year Divorced Yes 2 X No specify: "natural", White ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 12 VicePresident/CFO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tranmatic event. Be Henry Martin Ficken Nancy Barksdale 19a. Informant's Name/Relationship (Type, Print) Timothy Noell (spouse) If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date or other crematory or other place) 02 Pages 1 2 X Cremation 3 Removal from State Aug. Burial permit Pages
Department of
Important: I Metro Crematory Inc. 2008 Donation 5 Other 21. Signature of Foneral Service Lit 22. Name and Address of Facility 23a. Part I. Enter to disease, or cor that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on /Medical a. Subdural and Subarachnoid hemorrhage 了今~ Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) b. Ruptured berry aneurysm in association with cerebral contusions Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ysician a UNPENDED AMENDED phy: IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the for use as Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Completed 24a, Was an autopsy performed? death? ✔ Yes 2 No

2045 hrs

AL

10d. Inside City Limits

Yes 2 No

Equipment Sales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5339 Carroll Boyer Road, Middletown, MD 21769 20c. Location - City or Town, State Baltimore, Marylad ame and Address of Facility

Stallings Funeral Home, P.A.

3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of certificate has 1 🗸 Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other: this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 ✔ Yes 28a. Date of Injury (Month, Day Year) Jul 29, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto fixed object collision Natural Director: Pending Yes 2 ✔ No hours after death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be determined (Specify) Local Street Cherry Lane, Myersville, MD Homicide 29a. Certifier 241 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. July 31, 2008 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL **OCME 2006** OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** uens varre 2008 /Medical Eacility Name (If not institution, give stre ty, Town, or Location of Death 4c. County of Death Examiner Medica (enta HIMOr MOY Da If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1□M 2□F 577-42-5096 Director 75 Jan 3, 1933 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Item 27 Is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 301 Audrey Avenue 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XX es 2 □ No If Yes, Give 1952 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIo Specify. þ XXWidowed 4 ☐ Divorced White 1956 Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 9 College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) les 1 and 2 should be fill of Health and Mental H Franklin B. Owens 2 Katie Beall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Warren Owens / son Brooklyn Park, Maryland 21225 301 Audrey Avenue Pages 1 gment of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ortant: If I 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Crestlawn Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 8/8/2008 Marriotsville, MD 21. Signature of Funeral Service 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or con shock, or heart failure. List onl lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYDNIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) as the burial-Box 68760. physician the death certificate be Physician/Medical attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 X Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No certificate 1 ☐ Yes Yes 2 □ No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 3□ DOA 2 2 ☐ ER/Outpatient After this 27. Manyler of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide filled 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of sentifier 29c. License number 29d. Date signed (Month, Day, Year) 19024

10+1

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

zaineb makh wwmi

ure Moesta

M·D

State Registrar 10 N. Greene St Baltimox, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ckering 4:22 PM , 200 Tuly /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimor of mary land medical (on If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1 X M 2 □ F 219-40-9518 Director August 14,1943 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Heatth and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Im dical Examiner must be notified at uny or other traumatic event, the Im dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 117 Swarthmore Dr. United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) journalist newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Wolfrum Edgar R. Pickering P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 117 Swarthmore Dr. 21204 Judith Pickering/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Aug. 1, 2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. ending physician use as the buris IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6 T

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORMAN RETENER

MA

22 SOUTH



GREENS ST

P21136

BALTIMORE NO

7/30/2008

State of Marvland / Department of Health and Mental Hygiene Reg. No. 2008 25079 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Vear **Physician** July Marjorie Anne Ryder 29 2008 2:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard 8. Date of Birth (Month Day, Year) Mar 26, 1922 Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2 🔀 F Yrs 410-24-7185 Director 86 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6735 Allview Drive 21046 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Eliza Jones Evans Clyde Johnson Coker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6735 Allview Drive - Columbia, MD 21046 William Ryder - Son 20b. Place of Disposition (Name of cemetery crematory or other place)

Metro Crematory, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/08 Baltimore, MD 21. Signature of Funeral Service Frances

Thomas Gregor Thomas Gregor

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth, or learn failure. List only one cause on each line. 22. Name and Address of Facility 21228 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Suursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) plant and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) State AUG 0 Registrar

P.O. Box 68760,

Division of Vital Records,

			1- For State of Maryland / D	epartment of Certificate of		ygiene Reg. No. 2008 25080		
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) ELIZABETH 4a. Facility Name (If not institution, give street and number)	OD WELL	2. Date of I Month JVL	Death Day J Year 3. Time of Death 1328 M 4c. County of Death		
	Examin Funeral Director	er	The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore	City If Under 24 Hrs. 8. Date of E Hours Min. (Month, I	Birth 9. Birthplace (State or Foreign Country)		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyghene. Item 27 is marked other than "natural", or Items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State	10f. Zip-Code 10f. Zip-Code 13. Was Decedent of It Yes, specify Cut 1 Yes X No	21218 Hispanic Origin? (Specify Yes or Noan, Mexican, Puerto Rican, etc.) Specify: Ipation Industry of working	10d. Inside City Limits ★□ Yes 2□ No 10g. Citizen of What Country? USA		
Marylan	1 and 2 should be Health and Mental tem 27 Is marked of other traumatic eve	To Be Co	Tonjia Chalmers-Daughter 2. 20a. Method of Disposition 1. William 2 Communication 3 Removal from State Cermeter)	anber, City or Town, State, Zip Code) 20607 Ve Accokeek, MD 20c. Location - City or Town, State				
	permit. Pages Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		ess of Facility March North Avenue	F/H East Balto,MD 21202 y arrest, Approximate Interval Between		
ļ	requires that the death certificate be executed Way Way Hould be detached for use as the burial-transit Thould be detached for use as the burial-transit for use a	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause). Due to (or as a consequence of the cause).	TRICRY !	Disease	Onset and Death		
O. Box 68	ie death certificat the attending phy ched for use as th	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 9 Unknown	3 Ectopic pregnan 5 Other (specily)	су	23d. Date of delivery Month Day Year		
o	s b	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in	ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the second of th				
of Vital	Physician: The this certificate ral director, pa	To Be	27, Manner of Death 28a. Date of Injury 28b. Ti	ime of 28c. Inju	ry at 28d. Describ			
DIVISION	ai or Attending F s after death. I Director: After t d in by the funer	Certification:	1	njury Wo	rk?] Yes 2 □ No 28f. Location	n (Street and Number or Rural Route Number, own, State)		
	To the Hospital or visithin 24 hours after To the Funeral Director Completely filled in the Funeral Director Compl	edical	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my				
	# 3 # K		30. Name and address of person who completed cause of death (Item 23a) (R	ET-000	August 1 2008		
	4		SAMIT DESA		600 North W	olfe St, Baltimore, MD, 21287		

State Registrar

AUG 0 5 2008 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2008 Month **Physician** August 1, Ossie Romano 4:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eastpoint Nursing Home Dundalk Baltimore Il Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)
March 31, 1 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 225-30-8691 1 M 2 XF 80 Yrs. Director 1928 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow other traumatic event, the Midical Examiner must be notified at Md. Baltimore Sparrows Point 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2878 Nathaniel Way Apt E 21219 USA or Itema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Yes. Give Specify: þ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Hanger Co. 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown ပ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Hindle Granddaughter 2878 Nathaniel Way Apt. E Sparrows Point Md. 21219 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Dapartment of H Important: If ite any injury or ot once. Bayview Crematory or other pla August 4, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore City, Md. 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Juneral Service Licen 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Badder Immediate Cause (Final Quer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🗷 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Embolus moran 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this cartifica Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Yes Z No Other | Nursing Home | 5 | Residence | 6 | Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide cai 29a. Certifier TE Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) mpletely (Check unity one) and manner stated. 29b. Signature and Alle of certifier 29c. License number 29d. Date signed (Month, Day, Year, Oakwood Ild 31. Date liled (Month, Day, Year) 32 Registrar's Signature State 2008 AUG 0 5 Registrar

Certificate of Death

. Decedent's Name (First, Middle, Last) 2. Date of Death Marion Schweitzer Month Year 10:35a M Aug.1,2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard Columbia Vantage House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 10 / 1913 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1□M 2¬F Days Min. Illinois 333-05-4016 95 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Howard Columbia 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21044 5400 Vantage Point Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 TNo Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Palmer Raymond Flinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9221 Bells Mill Road Ted Schweitzer/Son Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 8/04/2008 Chesapeake Crem Beltsville, Md 4 □ Donation \ 5 □ Other (Specify) 21. Signature Funeral Service L PHILIPADS RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breas /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) assisted 1 ☐ Yes 2 TV No 2 ER/Outpatient 3 DOA 1 Inpatient 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 XNatural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Aug. 4, 2008 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willie Mvemba MD 413 Commonwealth Road Catonsville, Md 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 5 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day **Physician** 329 Stephens Edith J Juli 3008 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours Months Days 1 □ M 2 K I 2/19/1929 79 North Carolina 217-26-8285 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location id other than "natural", or items 23a or 28a-f show event, the "kedical Expressive that be netfilled at 1 ☐ Yes 2 TXNo Director MD Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 3595 Half Moon Glen 21122 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐NO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married S Tephens, Edith Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, The "diagonce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 Ticket Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Mae Bucker Henry Wilson Glace ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7809 Baltimore/Annapolis Blvd., Glen Burnie, MD 21060 David Jones/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/2008 Little Creek Hundred DE St. Stephens Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral St Stallings Funeral Home P.A. 3111 Mountain Rd., Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause deach line. Immediate Cause (Final **Physician** Beenst Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Dimonio. H2M2/mxxx3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should t Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐ Yes r this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 KER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident neral Director: , filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and til WD 1065726 31,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) itig ynas Wen Rurnie 801 48 Mp. 21061 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25084 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Lugus 2008 ivia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner atons 29 ille TIMOSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 3, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Min Hours 79 Yrs. Director 214-22-6773 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 715 Maiden Choice Lane Apt. CC-222 21228 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after reant of Heelih and Mental Hygiene.
ent: if item 27 ie marked other than "naturel", or lies ury or other traumatte event, its Marical Examina.
ury or other traumatte event, its Marical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretarv County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace Hance Julia Burrows ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane Apt.CC - 222 Catonsville, MD Notley F. Showe, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 08/04/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Triomas Gregor Cremationssociety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes t autopsy 2 1 N 1 Yes 1 Yes 2 No Be 25. Was case reterred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 146 ည 3 DOA After this funeral dir 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Naturat s efter de. rel Director; Alle hv the fir 5 Pending 1 Yes 2 No М investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide in 24 hour. the Funeral Directory 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d, Date signed (Month, Day, Year) ē

Registrar

State

Name and address

31. Date filed (Month. Day

Year)

AUG 0

Maiden

erson who compteted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MARIAN.

ONR

2008

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D47009

Choice Lane, Baltimore MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ank ocarborou	٠	1- For State Certificate of Death Registrar		a. No. 200	8 2508
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month July 29, 20		3. Time of Death 1945 hrs
iedicai Examin	iei	Frank Scarborough 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 29, 20	4c. County of Death	
		123 W. 29th Street Apt. 16 A Baltimore		N/.	
Funeral Director		220–40–7753 1X M 2 F 63 Yrs. Months Days Hours Min.		'	thplace (State or untry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show	5	MD N/A Baltimore			1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code 123 W. 29th Street, Apt. 16A 21218	10	g. Citizen of What Cour	ntry?
death wil	une	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: 12. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify:		14. Race - Ameri White, etc.	can Indian, Black,
hours a natura Sxamin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use retired.)		16b. Kind of Business/l	industry
136 hin 72 e. than ";	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 3 Salesman		Healthcar	e
5-00 led wit Hygien other	5	17. Father's Name (First, Middle, Last)			
21215-0036 uld be filed within 7 Mental Hygene. marked other than	Be o	Frank D. Scarborough, Sr. Pearlea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		-	Zin Code)
MD 2 d 2 shou lth and M m 27 is n aumatic	٩	Darrell Scarborough - son 66 Grand Avenue, New		07016	, zip Gode)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 7/3	Date 1/2008	20c. Location - City or Baltimor	
Baltir permit. F Departme Importar Injury or		21. Signature of Funeral Society Chemation Society	of Mary	land, Inc.	21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical』 ⊯ Examiner	İ	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, cate be executed physician and the burial - transit	al Ex	d			ļ <u></u>
60, ate be executed physician and ne burial - transi	Medical	UNPENDED		Loo L Data of Latina	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Other (Specify) 9 Unknown	ancy	23d. Date of deliver Month	y Day Year
O. B at the da 1 by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ires that the signed by	d by	alcohol abuse	1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
Division of Vital Records, lat or Attending Physician: The law requir rs after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	·	24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
Vital Recystician: The Infector, page	Be C	25. Was case referred to medical examiner? Description			
F Vit		1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Outsit		Residence 6 V Othe	r: Scene
on of on of on of on of one of the control of the c	ijij	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	280. Describe 1	low injury occurred	
Divisic ital or Atte irs after dea ral Director illed in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, Si		ural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
E % E 8	Me	29b. Signature and title of certifier O.C.M.E.		29d. Date signed <i>(Mo</i>	onth, Day,Year)
-6		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Sta Regist	ate rar	31. Date filed (Month, Day Year) 32. Registrate Signature			
DHMH 17 Rev 1/20		ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** FLORA MAY S. STEIN 2008 August pric /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heirford Air Health and rehebilitation 13e1 AIL If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 212-38-2671 July 4, 1910 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ Xuo Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ring Factory Road

12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | Mo
If Yes, Give
Year or Dates: 21014 Funeral 300 W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: þ Specify: 3 AWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Whiteford Streett Bessie Belle Scarborough 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel C.E. Stein / Son 334 Bahia Mar Dr., Apopka, Florida 32712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 KgCremation 3 ☐ Removal from State Hilltop Service Corp 8-4-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, 21. Signature of Funeral Service Licensee P.A. Tass 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neary disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2∏No 1 Yes 2 No 1 TYes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: To 1 ☐ Yes 2/X No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide i 🖄 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56545 € € 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 206 HAYS ST # 102, BELAIR, MD 21014 KHOSLA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08 Schwarz Almira Doris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Franklin Square caltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth **Funeral** Days Hours 1 M 2 DF 219 28 8616 Yrs. September 14 1929 Baltimore City, MD Director Usual Residence of Decedent 10b. County 10c. City. Town or Location or 28a-f show Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wodon Examinat has notified at Director Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 8409 Philadelphia Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Payroll Clerk Hutzler's Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Charles Edward Schwarz, Sr Marie Appel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. Joan B. Leiss (Sister) 2214 Park Drive Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. August 4 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Houte /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran

☐Yes 2☐No

29a. Certifier

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5

Medical

Physician/Medical Completed or Attending Physician: Be ျ Certification:

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records,

To the within 2 M

Hospital

9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manper of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

3 Ectopic pregnancy 5 Other (specify)

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9 Unknown

29c. License number

29d. Date signed (Month, Day, Year) 008

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

White

1 ☐ Yes 2 ☐ No

:14 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,9000 Franklin Square Drive, Baltimore, MD Dr. Mada 31. Date filed (Month, Day, Year)

AUG 0 5 2008 32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 000.5 M 10101 ice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 229-40-7741 Director 4-29-1936 VA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or 32222 Ravenwood Avenue 21213 U S Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ▼No 2 Specify: Black 3 Widowed W Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Civil Service Elementary/Secondary (0-12) College (1-4 or 5+ other than 12th grade N/A Graphic Artist 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be is marked of Flovd Wilev Annie Mitchell 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3222 Ravenwood Avenue Balto, MD 21213 Yvette Staton-Daughter of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-9-2008 Randallstown, MD Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H R lad 1101 E. North Avenue Balto, 21202 w and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year funeral director, page 2 should be detached for Month Day 5 Other (specify) Pregnant at time of death P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No 2 this certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \sum Nursing Home Hospital: Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: of or Attending Parter death. After Injury 5 Pending 1 🗌 Yes 2 🗌 No investigation eral Director: Af 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of cortifie 29d. Date signed; (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

Goods of s

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician elders Cecil 54-SOOS 2210 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Gwynn Oak Augsburg Lutheran Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) **XX**M 2□ F Days Months Hours Min Director 236-18-5363 87 May 08, 1921 Virginia West Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 United States of America 6811 Campfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 ☐ Never Married 🏠 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify White \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Electrician Mining es 1 and 2 should be filed w of Health and Mental Hygier f item 27 Is marked other tt 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Thurman Selders Nellie Edith Winters 19a. Informant's Name/Relationship (Type. Print Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun Mrs. Janet S. Kinneer 26 Riggs Road, Fredericksburg, Virginia 22405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 108/04/08 Aurora, West Virginia 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc. 21. Signature 8728 Liberty Road, Randallstown, MD. 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 ears /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. ed by the detached 9☐Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been sig ; page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Certification: or Attending .ospital ... 24 hours after dea... -ral Director: Aftr Injury 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident To understand Within 24 hours and To the Funeral Director To the Funeral Direc 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records,

To the Hospital

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who comp 71bell MD 32. Registrar's Signature

use of death (Item 23a) (Type, Print) 25 **ST** -

🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

037573

31,2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 25090 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Maces 1 10:18AM NAHSEE OLA 2, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Koad WICKLOW BALTIMORE If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗷 F 213-30-5690 75 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Itams 23a or 28a-f ehow any injury or order traumatic evant, Ita Marilial Examination must be notified a BALTIMORE ¥ Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street and Number 21229 u. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status 1 □ Yes 2 MarNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality CONTROL SUPERVISOR NIA 17. Father's Name (First, Middle, Last) Be VOHN SON ARON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Pouse 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 11/2008 OWINGS MILLS, MOT. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility D. CROMARTIC FX5 somtathe Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE **Physician** · YCARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physiclan a detached for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown as been sign 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? 2 2 No 1 Yes 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Injury 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifie

N.M. MACHIRA

31. Date filed (Month, Day, AUG 0

MAIDEN

ATTENDING

20 C 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

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29d. Date signed (Month, Day, Year)

2008

			For State Registrar	State of Mar	ryland / Depa	artment of F rtificate of I		nd Men		200	8 25091
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dong	/Medio		4a. Facility Name (If not institution	1100		4b. City, Town, or	r Location of F		14/4	315+ 202 4c. County of De	3
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	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. [Date of Birth Month, Day,		Birthplace (State or Foreign
	Director		219-26-7651	1 XM 2 ☐ F	68 Yrs.	Months Days	Hours		Month, Day, 1		Country) MARYLAND
	ㅁ .		Usual Residence of Decedent								
	arylan show	<u>.</u>	10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	MARYLAND PRING	CE GEORGES	UPPE	R MARBORO)				1 □ Yes 2/CINo
	or 2	Director	10e. Street and Number			10f. Zip Code			100	g. Citizen of What	Country?
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Maryland	2 should be and Menta is marked aumatic ev		19a. Informant's Name/Relations	nip (Type. Print)	19b. Maili	ng Address (Street	and Number	or Rural Ro	ute Number, e	City or Town, State	e, Zip Code)
	12 mg		Giovanna Taylo	r/Daughter				n Pkw	y, Upp	er Marbo	ro,MD 20774
ore	ges 1 If of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 Demoval from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other place	e)	Date	20	c. Location - City	or Town, State
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Bal	permit. Pages 1 al Department of Hee Important: If item any Injury or othe once.		21. Signature of Funeral Service	Lice isee	W	2. Name and Addre	BROWN		NITY F	UNERAL H	OME P.A.
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39	ertific ing p	Med	IF FEMALE:								
Вох	leath certifi attending for use as	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	☐ Ectopic pregnanc	y			23d. Date of Month	delivery Day Year
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σ.	that the		Part II. Other significant condition	ons contributing to death but	not resulting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contribute	e to the cause of death?
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	To the To the company of the the company of the the the the the company of the	Ĭ	29b. Signature and title of certifier			29c. Licens				d. Date signed (Mo	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TISHNER **Physician** 3:52 A M IHERESA *august* 01 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAUTIMORE BA YVIEW MED (ENI HOP KINS Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, March 4, **Funeral** 1□ M 2🗓 F 92 Pennsylvania 170-18-1737 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Events 200 or 28a-f show once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 XNo Funeral Director Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 6907 Dunmanway USA Apt E4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married White 1∐Yes 2∭XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 2 years Accountant 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Tishner Theresa Omerein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Long View Drive, Bloomsburg, PA. 17815 Jeffrey M. Helsel Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 5, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Bartholomen Cem. Wilmore, PA. 2008 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Si nature of Funeral Service Licensee 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) dux /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ending physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2XNo o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No 2 ER/Outpatient 3 DOA Inpatient Medical Certification: To this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. reral Director: , 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature an title of certia

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of

31. Date filed (Month, Day,

MART

EASTERN AVE.

son who completed cause of death (Item 23a) (Type, Print)

ARNAN

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 25093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Robert Lee Thomas 5:30 p Jul 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore Baltimore** Manor Care Health Services If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F **Director** Sep 29, 1926 419-28-0032 Alabama Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 No 2 No Director **Baltimore** Maryland **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Edmondson Avenue 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ X lo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. þ Black 3 □xVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steelworker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Belle Stallworth Unknown 2 injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau 1906 Rambling Ride Lane Baltimore, Md. 21209 Malcolm Thomas 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 □XSurial 2 □ Cremation 3 □ Removal from 08/01/08 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Park Cemetery 21. Signature of Furniral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 In 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death CONGES **Physician** 18 CARDIUMYOF disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for its a sone equance of: Examiner burial-transi and or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 10NEY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 2 **3**(No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 0059107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN, MO BUSINESS MA CENTER DRIVE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per FH 8882 8/5/08 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 (1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Year 4 м AVNS4TEYN 8.27 AUGUST 2008 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Months | Days 5. Social Security Number Birthplace (State or Foreign Country)
 UKRAINE Age (In yrs. last birthday) **Funeral** 0272871946 215-33-8568 62 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9 SANDVIEW COURT 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, Black, White, etc. WHITE 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CIVIL ENGINÉER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YAKOV VAYNSHTEYN BAYLA BRONSHTEYN ဂ္ 19a. Informant's Name/Relationship Gype. Print)
Ladyzhenskay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 SANDVIEW COURT, BALTIMORE, MD LADY ZHEMSKAY/WIFE MAYYA 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of LIBERT Nore page) SHAAREI ZION Date 20c. Location - City or Town, State RANDALLSTOWN, MD 4 Donation 5 Cother (Specify) 08/01/2008 21. Signature of Juneral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4 WEEKS /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit MULTIORG that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) the 9 Unknown Director: After this certificate has been signed by it in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Nnknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 🔲 Yes 2 □ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled in within 24 hours a chrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only onel 29b. Signature and title of certifier 29c. License number MU431 012008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /D CAPAVALURU UBBARAO 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature soul! State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Registrar Registrar Registrar Registrar 25095 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2008 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAI ong Grez Nursin Home Timore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1918 al Security Numbe -20-9043 **Funeral** Days Min. 1 □ M 2 K F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evant her is utilized at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 ☐ No Be Completed by Funeral Director AITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Jack 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ~ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICE Westinghouse Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STATON ပ 19a. Informant's Name/Relationship (Type. Print) ural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Illiams IE RETUD WOTBIT 5108 Ken 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 Removal from State MARYLAN 08-11-08 2BUTIIS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 122101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

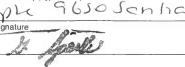
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	shock, or heart failure. List only	one cause on each line.				Onset and Death					
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	resulting in death)	Due to (or as a consequence of):									
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ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ppic pregnancy er (specify)		23d. Date of deli	very Day Year					
=	Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I.	use contribute to	the cause of death?						
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Сотріете				24a. Was an autopsy performed?	death?	topsy findings available ompletion of cause of					
e c	25. Was case referred to medical examiner?		26. Place of Death								
0	1 Yes 2 ™No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 41 Nursing Hon	ne 5 Residence	6 ☐ Other (Spec	sify)					
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Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office 2	8f. Location (Street City or Town, Sta	and Number or Ru te)	ral Route Number,					
edicai	29a. Certifier (Check only one) Certifying Photocal Example 2 Medical Example 2	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause ed at the time, date a	e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)						
₹	29b. Signature and title of certifier		29c. License number	29d. [29d. Date signed (Month, Day, Year)						
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Shalunmal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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NO

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			For State	State of Mai				Mental Hygie	2000	25006
			= State Registrar		Ce	rtificate of	Death	Reg.	No. 2008	25096
	Discouries		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
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10	Examin		4a Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deatl	h	4c. County of Deat	h
E.J.		3 ₅ .	BALLIMORE VAN	diCAL CO	Nter	+ALTIN	TORE		-	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. Birt	hplace (State or Foreign untry)
	Director		217-24-5830 ×	M 2□F	76 Yrs.	World Days	Tiodis Willi.	Mar. 28		Maryland
7	<u> </u>		Usual Residence of Decedent							
į	show 1 at	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f s	cto	Maryland N/	A	Ва	ltimore	:			1x Yes 2□No
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-	ems er m	ıne	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
9	or it	F	1 Never Married 2 Married	1 Yes 2 No If Yes, Give					Specify: Bla	
5-0036	Exa	d b	3 Widowed 4 Divorced	Year or Dates:	Confide					
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21	nled within Hygiene. other than ' ent, the Me		6th grade		11100	CIICUI			ailroad)
pu	ntal H Adotl even	Be	17. Father's Name (First, Middle, Last) Clarence B. Wat	ers. Sr.			Catheri	me <i>(First, Middle, Ma.</i> .ne Smith	iden Surname) L	
Maryland	z snould be filed with and Mental Hygie is marked other thraumatic event, the	၉		·						
lar	and is m raum		19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street	and Number or R	ural Route Number, C	ity or Town, State, 2	Zip Code) 21239
	permit. Pages 1 and 2 should be liled within 72 hours after death with the marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mildred Waters/	wife			tnern i	kwy Balt		
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Baltimore,	permit. Pages Department of I Important: If its any injury or of		4 □ Donation 5 □ Other (Specify,		Garrisc	on fores	st Veter	ans Cem.	Owings	Mills,:Md
alt	Depart Import any in		21. Signature of Funeral Service Licens	// _	2	2. Name and Addre	ess of Facility Ch	natmag-Ha	rris l'u	neralHome
<u> </u>	20 5 6 6		Derby A	aires		240 Rei	stersto	own Rd Ba	ltimore	,Md 21215
83		-	23a. Part1 Enter the dis se, or comp shr ck, or heart fair re. List only of	lications that caused to	he death. Do not en	ter the mode of dyi	ing, such as cardia	c or respiratory arrest		Approximate Interval Between
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	/Medical	Ш	resulting in death)	Due to (or as a	consequence of):	* 10.77	1)	1		
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<u></u>	I he law requires that the de ite has been signed by the a rage 2 should be detached t	V P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	furres T sign	d by						1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
00	w requir been si should b	Completed						24a. Was an	24h Were a	utopsy findings available
Be.	has ge 2	E D						autopsy	prior to	completion of cause of
ਰ								1 Yes 2		2 □ No
Z Z	ysician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ot	hor	ath (Check only one)		
ō	> .⊍ 0	은	1 Yes 2 No 27. Manner of Death	1 ☑ Inpatien 28a. Date of Injury		III 3 DOA	4 🗀 Nursing i	Home 5 ☐ Residend		ecify)
LO.	aling After funer	ion	1 Matural 5 ☐ Pending	(Month, Day	Year) Injury	Wo	ork?]Yes 2∐No	28d. Describe now	injury occurred	
Sic	Attending Physician: r death. ector: After this certifica by the funeral director, i	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of injur	y - At home, farm, st			Opt Location (Ctm	at and Alumbaras D	und Davin Alumbay
Division or Vital	or A after of Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	reer, ractory, office		City or Town,	et and Number or R State)	urai Houte Number,
<u> </u>	Hospital 24 hours a Funeral I tely filled		29a, Certifier 1 vertifying Phy	/sician: To the best of	Emy knowledge dee	th consurred at the	time date and at-	o and due to the	no(a) and	a atatad
	Hos 14 ho Fun tely t	ica	(Check only one)	iner: On the basis of	examination and/or it	nvestigation, in my	opinion, death occ	ce, and due to the cau curred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Pn within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of certifier	and manner stat	cu.	29c. Licen	se number	200	i. Date signed (Mog	th Day Year)
	Z ≥ Z ⊗		and the big carries				_		71	
			1000			7	16/18	/	0/7/0	0
7	541		30. Name and address of person who	ompleted cause of de	ath (Item 23a) (Type	, Print)	Congs	x 612	Rail -	ore MD 21201
			Steven Cynning 31. Date filed (Month Mag God) 5	MAM A Consister	r's Signaturet	NURTH	ONET	Theet	- DALLING	ることという
	Sta Regist	ate rar	AUG U 5	2008	r's Signature	John Service				

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			for Am State Registrar	end It	em 23a	of Ma per	aryland d r., g	l / Depa 882_g0	rtment 105/05/0	of He	ealth and N eath	Mental	Hygie Reg	ene . No. 2008	3 25	097
	Physicia	an	1. Decedent's Name (Helena	First, Middle,	Last)			Webb				2. Date Mont	h	Day 2 Year	3. Time (of Death
	/Medio Examin		4a. Facility Name (If n	ot institution,		number)		WEDD	4b. City, T	own, or L	ocation of Death			4c. County of Dea	, ,	
			BALTIMOZE	KX	HNGTON	me	>ICAL	_ CENT		GLE	n Bur			AHNE	Afeir	DEL
	Funeral		5. Social Security Num 212-07-58	t t	6. Sex 1 □ M 2 X 1 I	7. Age	e (In yrs. la 97	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date (Mon	of Birth th, Day, Y	^{6ar)} 1911 9. Bir	thplace (State	or Foreign
	Director		Usual Residence of De	1								May	1/,	1911	MD	
	uryland show	ı.		0b. County				Town or Lo							10d. Inside (
	the Ma	Directo	MD 10e, Street and Numb		rundel		Glen	Burn	ie	^odo			100	. Citizen of What C		s 2 X No
	3a or	E Di	308 Newfi		ad				210					.S.A.	ountry:	
	death	Funeral	11. Marital Status		12. Was D	ecedent E Forces?	er in U.S	. 13. \			panic Origin? (Sp Mexican, Puerto	pecify Yes		14. Race - Am		
36	4 within 72 hours after death with the Maryland glene. I than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at	by Fu	1 Never Married		ed 1 □Ye If Yes.	s 2.XXIN Give	10		1 □ Yes 2]		Specify:	7 mount, ou	<i>3.)</i>	Black, White	e,eic. √hite	
215-0036	hour hural		3 X Widowed 4 l	⊔ Divorcea 5. Decedent':		r Dates:		16a. Dece	dent's Usual	Occupati	ion		16	b. Kind of Business	/Industry	
215	within 72 iene. • than "ne the Medi	Completed	(Specify Elementary/Second	only highest	grade complete	ed) e (1-4or 5	+)	(Give life. 1	kind of work OO NOT use	done dui retired)	ring most of work	king	T		•	1
	filed wir Hygien other th		9		0			Homen	aker			/Fired A/		own Home		
Maryland 2	be od o) Be	17. Father's Name (Fig. Clarence V								8. Mother's Nam Annie M.			iden Surname)		
E Z	2 should be t and Mental is marked o aumatic eve	To	19a. Informant's Nam					19b. Mailir	ng Address (City or Town, State,	Zip Code)	
Ĕ	ss 1 and 2 should of Health and Mei item 27 is marke r other traumatic		Mrs. Elle	n J. B	angert/	Daugh	nter	706	Glenvi	ew Aı	nenue G1	len B	ırnie	e, MD 210	51	
altimore,	Pages 1 and the neut of He int: If item irry or oth		20a. Method of Dispos		3 ☐ Removal fro	m State	20b. Pla	ace of Dispo metery, cren	sition (Name natory or oth	e of ner place)		Date 29,	20	c. Location - City or	Town, State	- "
	5 29 .3		4 ☐ Donation 5	Dther (Sp	ecify)		G1		en Me			008		Glen Burn: ineral & (0.00
g	permit. Departi Imports any Inji		21. Signature	at Service	ens.		Mor							en Burnie		
			23a. Part 1. Enter the shock, or heart	disease, or of	complications the	at caused	the death.								Approxima Interval Be	
9.	Physician		Immediate Cause (Findisease or condition			WE		EHAL	- FY	ALLU	RE				Onset and	Death
	/Medical Examiner		resulting in death)	ì			a conseque	ence of): farct :	ion							
		Je.	Sequentially list condi- if any, feading to imme cause. Enter Underly Cause (Disease or inj	itions, ediale	b		a conseque		LON							
	be executed ician and burial-transit	Examiner	that initiated events	1	C		nsion									
8/60,	cate be executed bhysician and the burial-transit	E E	resulting in death) Las	sı .			a conseque yroid									
/89	ificate g phys	edical			d	•										
X R R	death certificate e attending phys ed for use as the l	Physician/M	IF FEMALE: 23b. Was decedent print the past 12 mg		23c. If yes,		of pregnan		Ectopic pre	egnancy				23d. Date of de	•	Vaar
	he dea the at	ysici	1 ☐ Yes 2 ☑ N 9 ☐ Unknown			regnant at nknown	t time of de		Other (spe					Month	Day	Year
٠ <u>.</u>	w requires that the de s been signed by the should be detached		Part II. Other significa	ant condition	s contributing to	o death bu	ut not result	ting in the ur	nderlying cau	use given	in Part I.	23e.	Did toba	cco use contribute t	o the cause of	death?
ıds	en sign	ed by											1 🗌 Yes	2 □ No 3 □ F	robably 4	Unknown
ပ္က	@ m C/	Completed										24a.	Was an autopsy	24b. Were a	utopsy finding completion of	s available cause of
<u> </u>	sician: The law certificate has b irector, page 2 s	Ş										10	performe Yes 2[d?// death?	s 2 No	
<u> </u>	siciar certif irector	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No		Hospital:			70.4		Othor	26. Place of Deat					_
0	g Phy er this eral d	n: T	27. Manner of Death		28a. Da	te of Injur	rv 2	28b. Time of Injury	it 3 □ DOA	ic. Injury a Work?	4 Li Nursing no			ce 6 ☐ Other (Speninjury occurred	ecify)	
sion	endln sath. or: Aft he fun	atio	2 Accident	5 ☐ Pending investiga	ation	ionin, Day	y, rear)	injury	М		s 2 🗆 No					
Š	lor Att after de Direct d in by 1	Certification: T	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Pi	ace of Inju iilding, etc	ry - At hon c. (Specify)	ne, farm, str	eet, factory,	office		28f. Local City	tion (Stre or Town,	et and Number or F State)	ural Route Nu	mber,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	edical C	29a. Certifier 1[(Check only one) 2[Certifying Medical E	xaminer: On th	the best of e basis of anner sta	f examinati	ledge, deatl on and/or in	n occurred a vestigation,	it the time	e, date and place nion, death occur	, and due rred at the	to the cau time, date	use(s) and manner a e and place, and du	as stated. e to the cause	(s)
	vithir No th	M	29b. Signature and thi	e of certifier	- 0			14.	29c.	License r	number		290	Date signed (Mon	th, Day, Year)	a
	(0)		30 Name and address	s of person "	the completed of	ause of de	eath (Item	23a) (Type	Print)	145	2144			uly of	~00	Δ
			Dabo	03	101 Ho	Spite	al d	rive	- G(Len	Bur	ue	m	D 2016		
	Sta		31. Date filed (Month,		187	. Registra	ar's Signatu	ire								
	Registr	air	AUG 0	5 2008	A State of	All all A	S.F. A	poses	<i>P</i>							

		1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H tificate of I	lealth and N Death	ental Hyوا ا	giene 008	25098	
Physic /Medi		1. Decedent's Name (First, Middle, Last) Alice D. 1	Voodward	3			2. Date of Dea Month	Day Year 2008	3. Time of Death 2:35 P M	
Exami		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death		
Funeral		Manor Care- Rux 5. Social Security Number 6. Sex		e (In yrs. last birthday)	TOWSO:	If Under 24 Hrs.	8. Date of Birt	Baltimore 9. Bin	hplace (State or Foreign puntry)	
Director		214-38-3564	M 2 ⊠ F	93 Yrs.	Months Days	Hours Min.	06/09/1	915 Mar	y land	
land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
Mary B-1 sh	tor	MD Baltimo	ore	Baltimo	re				1 □Yes 2√No	
or 28s	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?	
eath w	Funeral Director	9800 Britinay La	ane 2. Was Decedent B	Ever in U.S. 13.1	21234 Was Decedent of H	isnanic Origin? (So	pecify Yes or No	USA 14. Race - Ame	erican Indian.	
filed within 72 hours after death with the Maryland Hygiene. Thygiene. The Marical Examiner must be nutitled at the Marical Examiner must be nutitled at	by Fun	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	fYes, specify Cuba 1 □ Yes 2 🔀 No	in, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify: Wh	e, etc.	
72 hour		15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king	16b. Kind of Business.	/Industry	
d within glene. In than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	sekeepe:			Resort		
ine, what yielled Kitz Coooooooooooooooooooooooooooooooooooo	To Be C	17. Father's Name (First, Middle, Last) Harry Walter Day	vson			18. Mother's Nam France:		Maiden Sumame)		
d 2 shouth and Mth and Mth and Mth trainingt	-	19a. Informant's Name/Relationship (Type Brenda Stadler/		0000	•			er, City or Town, State, e, MD 21234		
Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R		20b. Place of Dispo cemetery, cref Evans F	sition (Name of		Date 05/08	20c. Location - City or	Town, State	
		`4 □Donation 5 □ Other (Specify) 21. Signalure of Funeral Service License		Chapel-	Bel Ai:	r ¦		ForestHil	<u> </u>	
permit Depart Import any in		Malguetia	Dicel	70 8	800 Har	ford Rd	. Parkvil	remation Se le, MD 2123	3.4	
Physician		23a. Part 1 Enter the disease, or compli- shock, or heat failure. List only on Immediate Cause (Final dise e or condition	cations that caused e cause on each lir A	. /	13		or respiratory a	rrest,	Approximate Interval Between Onset and Death	
/Medical Examiner		reming in death)	Due to (or as	a consequence of):	Aclvana	000			= (vach)	
P H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as	a consequence of).	(0000				9	
cate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):						
	dicai									
Physician: The law requires that the death certit this certiticate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	livery Day Year	
that the	by Phy	9 ☐ Unknown Part II. Dther significant conditions con		ut not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use contribute t	o the cause of death?	
w requires the second bear signer should be contact the second bear signer should be contact the second bear							1 🗆	Yes 2□No 3□P	robably 4 Onknown	
The law require has been age 2 shoul	Completed						24a. Was auto perfo	an 24b. Were a prior to death?	utopsy findings available completion of cause of	
VICAL iclan: Ticlan: Sertifical ector, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea			2010	
Physic This ce	ျ	1 Yes 2 No	ospital: 1 Inpatie	The second secon	II JUDON			dence 6 Other (Spe	ecify)	
tending last.	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 285. Time o	Wo	yat rk? Yes 2 □ No	28d. Describe	now injury occurred		
or Atternation Atternation Oil Ctol	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Dir ctor: Alier this certificate has completely tilled in y the funeral director, page 2	edical C	(Check only 2 Medical Examinate)	ner: On the basis o	f examination and/or in	vestigation, in my	pinion, death occu	rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
To the within To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)	
) The			D6	1731		8/3/08		
8		30. Name and address of person who con the second s	mpleted cause of c	leath (Item 23a) (Type,	Print)	He209, A	Balto N	no 21204	P	
	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	2 -			<u> </u>	1	
Regis	trar	1110 0 5 21	2018	Par 1	Provide s					

ORIGINAL

WOODWARD 6/9/

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 for State Registrar 25099 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 3, 2008 11:35PM Marjory J. Wagner /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min Director 541-20-6676 82 January 15, 1926 Oregon Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mastical Experiment must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4710 Bethesda Avenue #611 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947-1951 1 ☐ Yes 2 📉 No Specify ð Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Grants Specialist H.E.W. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ralph H. Kletzing Helen Blackwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Robert M. Wagner/ Son 2533 Ironwood Court, Orange Park, Florida 32065 20b. Place of Disposition (Name of competery, crematory or other place)
Montgomery
Crematorium, Inc. 20a Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) oriúm, Inc. 4,2008 | E 22. Name and Address of Facility Robert A. Pu Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814-3501 Bethesda, Maryland 21. Signature of Funeral Service Licenses Pumphrey Funeral Home/ M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any adding to make the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 1 ☐ Yes Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ō this Certification: To After thi To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OIMD 00057124 814108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.5622 Shields Drive, Bethesda, Maryland 20817-3532 Truong Bao, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 5

08/03/

WAGNER, MARLJORY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar **Physician** 19:31 M July Rickie Alexander 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 № M 2 🗆 F Months Days Hours Min. Director 224-06-3950 Dec. 12, 1960 Alabama Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1X Yes 2 No Director MD Wicomico Delmar the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21875 U.S.A. 800 E. Chestnut Street Apt. 1006 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 1279es 2 D No 198
If Yes, Give Ye ar or Dates: 198 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1981altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1982 "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Residential 11 Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental in them 27 is marked of item 27 is marked other traumatic ev Anniebell Bryant Reuben Alexander 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 1006 Delmar, MD 21875 (Wife) Luretta Alexander 800 E. Chestnut Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Stephens Cemetery 07-15-2008 4 Donation 5 Dother (Specify) Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home E. Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** accident disease or condition resulting in death) Cerebrovascular hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: perform 2 No 1 ☐ Yes 2. INO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

B. Silvia

her les

31. Date filed (Month, Day, Year)

D30853

Penincula Regional Medical Center

Amend #26&29d.perPhys Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PGC 7/23/08 hh State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 17,2008 **Physician** Dansie Ayers 1:00pm M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Anne Arundel Household of Angels 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 256F 100 Massachusetts Director 434-32-5605 Sept. 28, 1907 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Exacting the relitied at 10d Inside City Limits MD Prince George's Bowie Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12312 Kemmerton Lane 20715 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Government Professional Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: if item 27 is marked ott Thomas Dansie Caroline Grist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Thrift/Daughter 12312 Kemmerton Lane Bowie MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 00 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Ft. Lincoln Cemetery 7/22/2008 *4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie MD 20715 Maria Salde 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician contc Conges minute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed as the burial-translt attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Armstrong 14201 Lance/ PK. Pr. 4/02 M12. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11 2 3 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22 00P M EVELYN APPELBAUM JULY 20 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 7, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 💢 F 95 1912 Director 100-09-6506 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 □ Yes 2 No Maryland Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6111 Montrose Road #523 20852 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson Retail other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Anne Moscowitz Jesse Herbert Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 206 E. Schuyler Road, Silver Spring, MD 20901 Jessica Singer, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/08 Adelphi, MD Mt. Lebanon Cemetery 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RENAL FAILURE /Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit CLOSTRIDIUM DIFFICILE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PHEUMONIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an has autopsy 2 🗹 No 1□ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

JUL 2 2 2008

HUBBLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)



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permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.

Baltimore, Maryland 21215-0036

within 2

Completed GLAUCOMA, HYPOTHYROID, HYPERTENSION 25. Was case referred to medical examiner? Be 1 TYes 2 TNo Certification: To 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Barbara superich Psu up D 0065485

State Registrar

31. Date filed (Month, Day, Year)

BARBARA SUPANICH, RSM MD 1500 FOREST GLEN RD., 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elsen It Sports

2008

SILVER

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 18 2008 06:00 A M Wilma E. Ambrose /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/16/1913 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 T Months Days Hours 94 193-38-2541 Director Pennsylvania Usual Residence of Decedent 10c. City. Town or Location r 28a-f show notified at 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I 2016 Governor Thomas Bladen Way 21401 United States filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 þ Specify. 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 Pages 1 and 2 should be filed vent of Health and Mental Hygie int; If item 27 is marked other it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Filosi Ann Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 Governor Thomas Bladen Way, Annapolis, Maryland 21401 Barbara A. Marino/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Entombment 07/24/2008 | Pittsburgh, Pennsylvania Calvary Cemetery 21. Signature of Fu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. aldian Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) AS SUSCEC 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

State Registrar

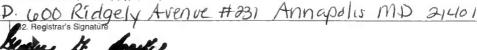
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and



29c. License number

D57028

29d. Date signed (Month, Day, Year)

07-18-08

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ī	57171		Decedent's Nam	e (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
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	Examin		4a. Facility Name (_	ımber)		4b. City, Tov	n, or Loc	ation of Death			. County of Death	
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	Funeral		5. Social Security N		6. Sex 1 [X] M 2 □ F	7. Age (In yrs.	last birthday) Yrs.			Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or Foreign intry)
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•	/Medical		resulting in death)		Due to	(or as a conseq	nce of):		O.					
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VISION	nding th. r: Afte e fun	atio	Natural 2 ☐ Accident	5 ☐ Pending investig		onth, Day Year)	Injury	М		2 □ No				
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	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only	1 Certifying	g Physician: To the Examiner: On the	basis of examina	owledge, dea ation and/or i	th occurred at t nvestigation, in	the time, o my opinio	date and place, on, death occur	and due to the red at the time	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
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•			30. Name and add	iress of person	who completed car	use of death (Ite	m 23a) (Type	Print)	· 1	, 0 /		4	8 /	- 0
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	Sta		31. Date filed (Mo	nth, Day, Year)	08	Registrar's Sign	ature Ana	de)			/			
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State of Maryland / Department of Health and Mental Hygien & U

1 - State Registral Certificate of Death

Physician /Medical Examiner

Funeral

Director

within 72 hours after death with the Maryland rai', or itams 23a or 28a-f show Examinar must be notified at "natural" The Medical s 1 and 2 should be fit I Health and Mental H Item 27 is markad ot

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records.

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr once.

sicien and burial-transit The law requires that the death certificate be executed attending physicien for use as the buria the t signed by the page 2 s certificate this Diractor: After the death. hours after ò within 24 hours a To the Funaral C

8 200 State

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death PATRICIA Queenie Brown 07/05/2008 9:20 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7406 Webster Lane Temple Hills Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F 577-92-6331 46 04/21/1962 So. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges 1 Yes 2 No Ft. Washington Funeral Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7406 Webster Lane 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed. Elementary/Secondary (0-12) College (1-4or 5+) Statistician 0 - 12Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Brown Sr. Arlene Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlene Lowery/mother 4202 13th St. NW #313, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cem. 07/12/08 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility REESE PROFESSIONALFUNERAL SERVICE, 3605 14th St. NW Washington DC 23a. Part1. ENer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia weeks Due to (or as a consequence of): Anoxic Enephalopathy months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner months Complications of Thyroid Surgery surgery Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Multinodular Goiter with Compressive 1 Yes 2 XNo 3 Probably 4 Unknown Completed Symptoms 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 🔀 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home S Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47654 07/07/08 nus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte Dean, MD 110 Irving St. NW Washington, DC 20010 31. Date filed (Month, Day)

DHMH 17 Rev 1/2001

Registra

			State of Maryl	and / Departmen Certificat	t of Health and Ne of Death	nental Hygier	2 008 2510	07
	Physician	1. Decedent's Name (First, Middle, L. Dana Violet Bl.				2. Dete of Deeth Month	Day Year 3. Time of 0	
E	/Medical	4a Fecility Neme (If not institution, gi			4b. City, Town, or L	July Organia	9 2008 11:44 4c. County of Deeth	pm
	Examiner	Garrett County	,	spital	Oakland		Garrett	
	Funeral Director	Social Security Number 6.	Sex 7. Age (In	yrs. last birthday) if Under Months	1 Year If Under 24 Hrs.	8. Date of Birth (Month, Dey, Yee Oct. 1. 1	9 Birtholace (State or	Foreign
		Usuet Residence of Decedent						
	show	10a. Stete 10b. County		City, Town or Location	0-1-1 A M	D 21550	10d. Inside City 1√2 Yes	•
	r 28a-f show	MD Garrett	. 8	9 Kelly Drive			Citizen of Whet Country?	
	with with Dir	89 Kelly Drive			1550		JSA	
	uter death with the Maryland if theme 23a or 28a-f show incer must be notified at Funeral Director	11. Maritel Stetus	12. Wes Decedent Ever	in U.S. 13. Was Deced	dent of Hispenic Origin? (Sp cify Cuben, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,	
Maryland 21215-0036	urs aftar Mr, or he cyamine by Fu	31X Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, spec		Rican, etc.)	Black, White, etc. Specify: White	
2-0	led within 72 hours ygiena. • The Medical Exit. It. The Medical Exit.	15. Decedent's E		16a. Decedent's Usua	al Occupetion rk done during most of work		Kind of Business/Industry	
21	within 7	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT us	se retired)			
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Ž	12 should be filed v h and Mental Hygie is marked other raumatic event, th To Be Co	19a. Informant's Name/Relationship		19h Mailing Address			y or Town, Stete, Zip Code)	
Ma	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic	1	1917			It Lake Pa	V	
ō,	s 1 and Health tem 27 other tr	Debra Baker (Data 20a. Method of Disposition	igiter)	Db. Place of Disposition (Nar cemetery, crematory or o			Location - City or Town, State	
9	ages ent of M: If I	1 ☐ Burial 2 ☑ Cremation 3 € 4 ☑ Donation 5 ☐ Other (Special	THemoval from State	VVU Memorial		Mor	gantown, WV	
Baltimore,	pemit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr pace.	21. Signature of Funeral Service Lice	1		nd Address of Facility		,	
Ö	Depariment important	Robert J. B	olyard per D	VR WVII H	uman Gift Re	ristry Mo	rgantown, WV 20	6506
	Physician /Medical	23a. Pert1. Enter the diseese, or conshock, or heert failure. List only	one cause on each tine.	death. Do not enter the mod			Approximate Intervat Betw Onset end D	veen
	Examiner	disease or condition resulting in deeth)	e Septicem	to (or es a consequence of):			days	
	J J		Pneumonia	The second secon			days	
	executed in and rial-transit	Sequentially list conditions,	b. Due t	to (or es e consequence of):				
30,	death certificate be executed e attanding physician and of or use as the burial-transit sician/Medical Examin	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury						
8760,	cate be e physician the buria	that initieted events resulting in deeth) Lest	Due t	to (or as a consequence of):				
9 X	rentification properties as as as as as as ar		d					
Box	that the daath certified by the attending detached for use as Physician/Me					1	1	
P.O.	the di y the ached	Part II. Other significant conditions	contributing to death but not	resulting in the underlying o	ause given in Part I.		co use contribute to the cause of 2∑ No 3 ☐ Probably 4 ☐ U	
	as that igned b be deta by PI	cerebrovascular	accident			1 105	ZE NO SEPTODEDIY 4	JIIKIIOWII
Records,	The law requiras that the death certivate has bean signed by the attanding page 2 should be detached for use a Completed by Physician/M					24a. Was en au performed	atopsy 24b. Were autopsy fin available prior to	
တ္တ	aw recus bear as sho pieto					periorined	completion of ca of death?	iuse
R	The law ate has page 2.					1 🗆 Yes	2 No 1 □ Yes 2⊠1	No
Vital	ysician: The secondificate director, pag	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
of V	S G S	examiner?	Hospital: 1 1 Inpatient	2 ER/Outpatient 3 DC	OA Other: 4 Nursing H	ome 5 🗆 Residenca	6 □Other (Specify)	
n.	ftar th Ineral	27. Menner of Deeth 1 ☑Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Yea		28c. Injury et Work?	28d. Describe how in	njury occurred	
Division	tal or Attending P rs after death. si Director: Aftar t led in by the funers Certification:	2 Accident investigation	00	М	1 Yes 2 No			t
Σ	or Att	4 Homicide determined	28e. Plece of trijury - / building, etc. (Sp	At home, farm, street, factory pecify)	y, office	City or Town, St	t and Number or Rural Route Numb late)	oer,
	oltal ours a curs a cur	200 Codifice 4 X Codificion III	hundelen. To the book of mu	leasulades double construed	04 Mar 4 ima data and alam	and due to the course	a/a) and manner on stated	
	To the Hospital or Attention 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my miner: On the basis of examend manner steted.	knowledge, deeth occurred mination end/or investigation	, in my opinion, death occur	red et the time, date	e(s) and manner es stated. end place, and due to the cause(s))
	Within To the comple		s mainor stoted.	290	c. License number	29d.	Date signed (Month, Dey, Year)	
	⊬ ≱ F ō	1 tol			D15333	(vi)	25/200	
	6	30. Neme end eddress of person who	completed cause of deeth	(Item 23a) (Type, Print)		0//	2/2000	
	5	Thomas Johnson,			up, 311 N Fo	urth Stree	t Oakland, MD	21550
	State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer's S	Signature Appell	j			

DHMH 16 Rev 6/95

ORIGINAL

Division or Vital Records, P.O. Box 68760.

Margaret M. Barnes

or Attending Physician: The law requires that the death certificate be executed Completed by certificate has irector, page 2 funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 ☐ Yes 1 Apatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058410 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 0.0 Day 1733 SALISBAY WO 21802 31. Date filed (Month, Day, Year) WARLS egistrar's Signature State JUL 22

Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

08-05496 Wille Mack Burks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State		Ce	rtificate of	Death					Reg. No)	00 201	
Physicia		1. Decedent's Name (First, Mi	ddle,Last)						2	. Date of De	eath Day	Year	3. Time of Death	
edical Exami		Willie M.	Burks							Month July 17,	2008	i cai	1855 hrs	
		4a. Facility Name (if not institu		number)		4b. City, Tov	vn, or Lo	ocation of	Death		4	c. County of De	eath	
		Auth Place & Britan				Temple	Hills					Prince Geo	rge's	
E	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of I	Birth (MN	A/DD/YYYY) 9.	Birthplace (State or	\neg
Funeral Director	- 1	417-54-9928	- 1/2	(2		Months	Days	Hours	Min.	T117 V	0.9	,1945 ^{Fo}	reign Alabama	
Director			1 X M 2	- 03	Yrs	5.			<u> </u>	o ar 1		71329		-
	_ <u> </u>	Usual Residence of Decedent 10a, State 10b, Cour		Inc. City	/, Town or Locat	rion		_	_				10d. Inside City Lim	nits
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and sho	5		nce Geor	ge CI	1110011						40- 0	::: of 141b of (
Maryland 28a-f show any d at once.	Director	10e. Street and Number		a .		10f. Zip C					1 -	itizen of What (Country :	
r death with the Maryland or items 23a or 28a-f shormust be notified at once.	ᡖ	8304 Dillio	onstone	Court		207					US.			
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eath item	Funeral	1 Never Married 2	Married Arme	d Forces?	"	es, specify	cuban,	Mexican,	rueitor	tican, etc.)				
— ier d		3 Widowed 4 X	Divorced If Yes, Give		1	Yes 2	X No	specify:				Specify: E	Black	
urs af tural	ğ	15. Decedent's Education (S	Specify only highest	grade completed)	16a. Decede	nt's Usual O	ccupatio	on (Give k	ind of w	ork done	16b	. Kind of Busine	ess/Industry	
2 hou "nai	粪	Elementary/Secondary (0-	12) Colleg	e (1-4 or 5+)	during n	nost of worki	ng life.	DONOT	use retire	ea)				
36 hin 7 than	힐	12th			Disa	bled					-1			
d with	Completed	17. Father's Name (First, Mid	dle, Last)		T D I Du	<u>orca</u>	1	8. Mother's	Name	(First, Middl	e, Maide	en Surname)		
al Hy	Be	Odell Pres					l	Stel	la	Bur	ks			
21215-0036 utilin 7 Mental Hygiene. marked other than it event, the Medical for the marked other than the medical for the marked other than the medical for the medica	0	19a. Informant's Name/Relati			19b. Mailin	ng Address				ural Route N	Number,	City or Town, S	State, Zip Code)	
MD 21215-0036 [257H] d 2 should be filted within 72 hours after death with the Maryland thith and Mental Hygiene no 27 is marked other than "natural", or items 23a or 28a-f sho an 27 is marked other than "natural", or items 23a or 28a-f sho namatic event, the Medical Examiner must be notified at once.	-	Tyrinia Mars	shall(Da	ughter)	B304	Dill	ion	stor	ne C	Court	,Cl	inton	20735 Maryland	
- P# # #		20a. Method of Disposition		20b	. Place of Dispo	sition (Name				Date	20	c. Location - Cit	ty or Town, State	
MOFE Pages 1 cent of H int: If it		1 X Burial 2 Crema	ition 3 Remov	al from State	crematory or o	ther place)	10	المده	11/	21		10:00	ala Va	
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Baltimore, permit. Pages I ai Department of He Important: If ite		21. Signature of Funeral Ser		(01.	In.	Name and A	T	VOL	1n.a	710	Kon	Wash	DC 20011 Street NW	- 1
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Physician		failure. List only one ca	e, or complications to use on each line.	at caused the dea	In. Do I Di Sinter	the mode of	uying,	30011 03 00	ai dido oi	respiratory	u		Between Onset a Death	
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	ايا	Sequentially list conditions,	b	as a consequence	of):		_							\neg
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ex ian	י/Medical	X UNPENDED	AMEND	_{ED} 23a,PI	1,27,28	a−i,	perN	4Ε, g	882	8/6/0)8 T	ľ	İ	
Box 68760, a death certificate be exthe attending physician ed for use as the burial.	٩ ٩	IF FEMALE:		es, outcome of pre								23d. Date of de		
rtifica ing p	교	23b. Was decedent pregnant past 12 months?	1	ive birth		etal death	3	Ectopic	c pregna	incy	- 1	Month	Day Year	
Box 687 e death certifi the attending	siciar	1 Yes 2 No 9	Unknown	regnant at time of	death 5	Other (Spec	ify) _				- 1			- 4
e der feel feel feel feel feel feel feel fe	Phy		9 0	Inknown	t the sign that	undorlying	201100	rivon in Ps	art i	23e D	id tobac	co use contribu	ite to the cause of death	?
P.O.	by F	Part II. Other significant co	naitions contribut	ng to death but no	resulting in the	undenying	cause g	givoninire	ai (1.			2 V No 3		
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ifical	ပိ	25. Was case referred to me	edical				6.Place	of Death	(Check	only one)				
Vital Recc ysician: The lav his certificate ha director, page 2	B B	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 D	DA	Other ₄	Nursir	ng Home 5	Res	sidence 6	Other: Scene	
FV Phys er thi	-	1 Yes 2 No 27. Manner of Death	28a.	Date of Injury	28b. Time o	f Injury 2	8c. Inju	ry at Worl	</td <td>28d. Pesc</td> <td>ribe how</td> <td>injury occurred</td> <td>to high</td> <td></td>	28d. Pesc	ribe how	injury occurred	to high	
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Sior Attend r death ector: by the	lä	77	Investigation //	17/08 Fno	1 0 : 4 Z I	om FN(I							emperature or Rural Royte Number,	City
Division of Vital Records, pital or Attending Physician: The law requir ours after death. For the filter this certificate has been similarly the funeral director, page 2 should by the funeral director, page 2 should be	Certification:		Could not be				000	ounding, o		or Tov	wn, State	e) Temp	or Rural Route Number. le Hills, M ania Way	ID.
Spita Spita hours neral	S	4 Homicide	1100	ecify) found			d	-1						- 5
e Ho n 24 l e Fu letely	cal	one) a Madient	ng PH sician: To the xaminer:On the b	e best of my knowl asis of examination	ledge, death occ n and/or investio	curred at the dation, in my	time, a	ate and pr n, death or	ace, and ccurred a	at the time,	date and	d place, and du	e to the cause(s)	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifuin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deatched for use as	Medical	/	and man	ner stated.				se number					(Month, Day, Year)	
//	Σ	29b. Signature and title of c	ertified			290						July 18, 200	_	
11		" // .	// /				O.C.	.ivi.⊏.						
1		30. Name and a ress of		cause of death (If						45.0:00				
OCME		Mary G. Ripple Mi	D. Deputy Ch	ief Medical Ex	kaminer 1	11 Penn	Stree	t, Baltin	nore, N	иD 21201	1			
	State	31. Date filed Moeth, Day	(sar)	2. Registrar's Sign	nature					-				
Regi		• 11.11 Z. 3. / []][U <i>PKA</i>	. //										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg, No. 2008

			1 - State Registrar	•	Ce	rtificate of	Death		Reg. No	2008	251	
100	A DECIM	-7	Decedent's Name (First, Middle, L.	ast)				2. Date of D	eath		3. Time of [Death
7	Physici /Medic		Kevin Orlando B	ishop				July 1	19, 2	2008 Year	20:04	\mathbf{P}^{M}
	Examin		4a. Facility Name (If not institution, g Southern Marylan			4b. City, Town, c	n Location of Deat	h	4c Pr	County of Dear		
	Funeral Director		225-02-9742	Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth Day, Year 24, I	9. Bird 959 Ma	hplace (State or untry) ryland	Foreign
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City	v l imits
	e Maryla 3a-f shov tiffed at	Director	MD Prince		andywi	ne					1 ☐ Yes	
	ath with th 23a or 24 ust be no		8611 Lonicera Co	urt		10f. Zip Code 20613			τ	tizen of What Co		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or N to Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: B		
15-0	in 72 ho n "natur I-dical	Completed	15. Decedent's (Specify only highest of	rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	rking	16b. K	(ind of Business	Industry	
212	filed withi Hygiene. Ither thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		l Supply			Go	overnmen	t	
Baltimore, Maryland 21215-0036	12 should be filed wand Mental Hygie o and Mental Hygie is marked other traumatic event, th	Be	17. Father's Name (First, Middle, La. Oscar Arnold Bis				18. Mother's Na Geraldi			n Surname) n Sturdi	vant	
2	should be and Mental s marked o	မ	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or R	ural Route Num	ber, City	or Town, State, 2	Zip Code)	
Š	1 and 2 Health a em 27 is		Londale Bishop -	wife	8611	Lonicera	Court,	Brandyw	ine,	MD 2061	.3	
ore	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other pla		Date	20c. L	ocation - City or	Town, State	
Ē	Pages tment of tant: If its jury or o		4 □ Donation 5 □ Other (Spec	city) Res		ion Cem.	7/26			inton, M		
e R	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lig	Schoson		2. Name and Address 503						
Ι.			23a. Part. Enter the disease, or co	nplications that caused the deat y one cause on each line.							Approximate Interval Betw Onset and D	e veen
	Physician	i	Immediate Cause (Final disease or condition resulting in death)	a Advanced	panen	atic Can					un Kno	
	/Medical Examiner		resusting in death)	Due to (or as a conseq	uence of):							
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	u <i>e</i> nce of):							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C								
0,	certificate be executed rding physician and ise as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):							
68760	cate b physic the b	Medical		d								
Box 6	death certifica e attending pl ed for use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna	al death 3[⊒Ectopic pregnanc	у			23d. Date of de Month		/ear
	00	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of d 9⊡Unknown	leath 5L	Other (specify) _					,	
P.0	The law requires that the de te has been signed by the a age 2 should be detached f		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Dio	d tobacco	use contribute to	the cause of de	eath?
rds	w requires been sign should be	ed by						10	Yes 2	!□ No 3□ P	robably 4 🕱 U	Inknown
Vital Records,	e faw re has bee je 2 sho	Completed						24a. Wa	as an	24b. Were a	utopsy findings a	available
ř		Com						per	formed? 2 ∑ (No	death?		436 01
/Ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	Hospital:			26. Place of De	ath (Check only	one)			
0	Physic this cral dire	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatie	IL OLL DOX		Home 5 ☐ Re		6 ☐Other (Spe	ecify)	
O	Iding File.	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No	200. Describe	o now inju	ny occurred		
Division or	or Atter after dea Director in by the	ertification:	3 Suicide 6 Could not 4 Homicide determine		ome, farm, st	reet, factory, office			(Street a own, Stat	nd Number or R e)	ural Route Numb	ber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, deal	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the curred at the tim	ne cause(s e, date ar	s) and manner a nd place, and du	s stated. e to the cause(s))
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens				ate signed (Mon	th, Day, Year)	
	1) Rate Fr			D4 3	446		7	20.08		
	6		30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type,	Print)	6.4 2 2	(1, 1, 1, 1)	C.0		7	•
	,	te	Roint AN FARA! 31. Date filed (Manth Pen Sear)	1 FAR M.D 980	of Co	ryeg Ave	Just 5-3;	LILLVER	1 12/	CING MI	0 2090)	k

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar Amended #31 Per PGVR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Baron C. Bass ĨO, 2008 2:39a.M July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours 437-27-5820 8/4/1932 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. The trains are 12 is marked other than "natural", or items 23a or 28a-f show and it of the trainmatic event, he Medical Exercises outs he notified at my or other traumatic event, he Medical Exercises outs he notified at 1 Yes 2 No Director M D Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 9004 Hewlett Drive 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CPA Accounting 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Harris Ben Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9004 Hewlett Dr., Ft. Wash., MD 20744 Sarah B. Bass/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Important: If any Injury or 7/19/2008|Malakoff, TX Steen 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Lorns 6500 Allentown Rd., Camp Springs,MD 20748 Approximate Interval Between Onset and Death complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a Part 1. Enter the disease of shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Overwhelmin /Medical Due to (or as a consequence of): Examiner Non-honghin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed hyprattasiva

Due to for as a consequence of): and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1∐Yes 2∐No ours after death.

eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Ce 🗀 ei 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Noo28736 Scataway Rd Svite 300 Clinton MD20735 2008 June & July ho completed cause of death (Item 23a) (Type, Print)

State Registrar

Date filed (Month, Day,

DHMH 17 Rev 1/2001

SHO

ORIGINAL

32. Registrar's Signature

JUL 2 3 2008

		1 - State Registrar	State of Maryland			of Health			giene Reg. No.	008	25113
	96	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
Physic		WILLIAM EDWARD	BELL, JR.					Month July	13 °	Year	1:15 A M
/Med Exami		4a. Facility Name (If not institution, give st			4b. City, To	own, or Location	n of Death	oury	7	ounty of Deat	
Exami	illei	CHARLOTTE HALL VET			Charl	otte Ha	11			St. Mar	~v
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1		er 24 Hrs.	8. Date of Birt (Month, Day	h	9. Birt	hplace (State or Foreign untry)
Director		579-16-8888 1L*	^{M 2□ F} 85	Yrs.	IVIOTICIS I	Days	,,,,,,,	05-20-1	923		n.,DC
P.		Usual Residence of Decedent	10c City	, Town or Lo	nation						10d. Inside City Limits
aryla shov d at	-	10a. State 10b. County									1 ∰Yes 2 □ No
Ba-f	Director	Maryland Anne Arund	el	Harwo	1				10 0'''		
or 2	Dir	10e. Street and Number			10f. Zip C				•	n of What Co	untry?
17-0000 172 hours after death with the Maryla "natural", or items 23a or 28a-f shot odical Examiner must be notified at	Funeral	4406 Sands Road	0 W D J J D J J D	2 40 1	Mar Danida	2077		aif. Van an Na		JSA . Race - Ame	rican Indian
er de item	nu	11. Wanta Glada	2, Was Decedent Ever in U.: Armed Forces?	5. 13. 1	f Yes, specif	nt of Hispanic C y Cuban, Mexic	oan, Puerto I	Rican, etc.)	. '"	Black, White	
s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∑3Yes 2 ☐ No If Yes, Give Year or Dates: WWTI	-	1 ☐ Yes 2	⊒No <i>Specif</i>	fy:		S	pecify: B1	lack
hour se Es	ed	15. Decedent's Educa		16a. Deced	lent's Usual (Occupation			16b. Kind	of Business/	
in 72 in 72 in ma	plet	(Specify only highest grade	completed)	(Give	kind of work OO NOT use	done during me	ost of workir	ng			
with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Ca	ab Dri	ver		ĺ	Self-	employ	red
Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mot	ther's Name	(First, Middle,	Maiden S	urname)	
ic ev	10 B	William Edward Be	11, Sr.			Ha	rriet	t Robin	son		
ite; INIAI ylatifical ELELISTONOSO strand 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	ng Address (5	Street and Num				Town, State, 2	Zip Code)
IN alth a salth a 27 is		Larry Bell/son		4400	Sands	Road	Harwo	od. Mar	vland	20776	<u>;</u>
item othe		20a. Method of Disposition		lace of Dispo	sition (Name	e of	D	ate		tion - City or	
Dallingle, IN permit. Pages 1 and 5 Department of Health Important: If item 27 any injury or other tr		1 図 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State			Cemeter	07–18-	-2008	Che1t	enham,	Maryland
mit. I sartm		21. Signature of Funeral Service License				Address of Fac					
Departing Department of the part of the pa		rack A will	20274110101	Ce	edar H	ill FH	4111	PA Ave.	Suit	land,	MD 20746
174		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused the death								Approximate Interval Between
Physician		Immediate Cause (Final	ARRHYT	H M	гΑ					17	Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ		111						
Examiner			CARDIO		MON	MARY	A	RREG	T		
<u> </u>	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ						-		
cuted d ansit	Examiner	Cause (Disease or injury that initiated events	PROSTA	TE	CAN	UCER	-				
exec	EX	resulting in death) Last	Due to (or as a consequ	uence of):							
The law requires that the death certificate be executed the has been signed by the aftending physician and bage 2 should be detached for use as the burial-transit	dical	d.									
rtifica ng ph as th	Jed	IF FEMALE:									
ath cer ftendin or use	an/le	230. Was decedent pregnant	Bc. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	incy I death 3 [Ectopic pre	gnancy			23	d. Date of de Month	•
ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d 9□Unknown		Other (spec					MOHITI	Day Year
w requires that the death certific been signed by the affending p should be detached for use as:	Physician/Me	9 Unknown		ne e de de co				Don Did A		a a a matella suba a tu	o the cause of death?
es the igned	by	Part II. Other significant conditions confi	•	uiting in the ui	ndenying cau	use given in Pai	π ι.				robably 4 🗗 Onknown
law requires t as been signe 2 should be	Completed							10	Yes 2□	NO 3 P	
law law as be	ble	- HYPERTE	NOTON					24a. Was	osy	prior to	utopsy findings available completion of cause of
The ate h	Š							perfo	rmed?	death? 1 □ Yes	2 □ No
sian: ertific ctor,	Be (25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check only o	ne)		
Physician: The law rthis certificate has tral director, page 2 s	10	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐				Nursing Hor	me 5□Resi	dence 6	□Other (Spe	ecify)
ng P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	c. Injury at Work?		28d. Describe	how injury	occurred	
endl sath.	Certification:	2 Accident investigation			М	1 ☐ Yes 2					
r Att	ij	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specification)	ome, farm, str y)	eet, factory,	office		28f. Location (City or To		Number or R	ural Route Number,
ral D											
Hosp 4 hou Fune ely fii	cal	(Check only 2 Medical Examin	ician: To the best of my kno ier: On the basis of examina								
To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one)	and manner stated.		290	License numbe	or .		29d Date	signed (Mon	th, Day, Year)
Sol Wit		29b. Signature and title of certifier	. MD		_					· 4	
SIC		Menalle				677	88		/	17	
3		30. Name and address of person who con		1 23a) (Type,		0 Charl	lotto	H ₂ 11 D	i Ch	arlott	20622 e Hall,MD
	toto	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	<u> </u>	onar1	LULLE	TOTT VO	i. OII	AT TOLL	- 11011191110
S	tate	1111 2 1 2008	1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month Miriam H. Bowen **Physician** A^{M} 9:49 July 20. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Potomac 8912 Belmart Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/24/1932 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗓 F 212-32-6024 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Extr. the must be a sufficed at 1 □Yes 2 No Potomac Maryland Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 8912 Belmart Road United States 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White \$ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Heller Jr. Grace Warehime ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health an Important; If item 27 is any Injury or other traus Patrick Bowen / Spouse 8912 Belmart Rd. Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney 7/25/2008 Valley Mem. Gardens Timonium, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Carcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 13 Years Cancer of the Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as # psysequence off; Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yea in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Atrial Fibrillation, Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2X No 1 ☐ Yes 2 ☐ No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{XResidence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ሼ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0014116 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald I. Shugoll MD 5530 Wisconsin Ave. Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 22 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** William Joseph Breslin 6:50 p July 19 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens at Riderwood Village Prince George's 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. 1 X M 2 □ F 324-07-9334 Director Illinois 89 1918 Aug. 19, Usual Residence of Decedent .1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

The 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Silver Spring | 10f. Zip Code Maryland Montgomery 10g. Citizen of What Country? 20904 3126 Gracefield Road, BG124 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1941-45 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade com grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Survey Statistician Bureau of Census 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cormack Breslin Rose Devaney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Martha Maria Breslin/Wife 3126 Gracefield Rd., BG124, Silver Spring, MD 20904 Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Nother (Specify) entombment Gate of Heaven Cemetery July 2008 Silver Spring, Maryland of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1, Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a. Pneumonia /Medical Due to (or as a consequence of): Examiner b. Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed Chronic Renal Insufficiency and that initiated events burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown à nas been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 🗆 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 🖈 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 x atural 1 ☐ Yes 2 ☐ No ours after death neral Director: / filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number humang July 21, 2008 D59524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Loveen Puthumana, 31. Date filed (Month, Day, Year) 320 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#23aI+II,perMD7/23/08,PMW,MccoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 20NALD BENNET 2008 SHO /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner 7. Age (li **Funeral** Months 578-48-4017 Usual Residence of Decedent Days Hours 10X M 2□ F Director death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zipvoode 10g. Citizen of What Country? 20 ural", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **™** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, Be ဥ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Brother Health em 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) City or Town, State 20a. Method of Disposition 20c. Location permit. Pages 1
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once, 1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lia 21. Signatu 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Bacteremia Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) REWAL FAIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABRIES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Diabetes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 Impatient 2 ER/Outpatient 3 DOA Certification: To nours after death. neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

SMBYASACH

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAR



7600 CARROLL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:19 p^M C. Bouza 20, 2008 Lucy July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery

Rirthplace (State or Foreign Sligo Creek Nursing Home

5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) Takoma Park der i Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🕱 F Yrs. 82 23. 1926 Louisiana 112-16-2938 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show event, the Medical Exactings must be notified at 1 ☐ Yes 2 XNo Director Takoma Park Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 1 and 2 should be filed within 72 hours after death with USA 20912 7525 Carroll Avenue Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ≥ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) iene. than Elementary/Secondary (0-12) College (1-4or 5+) County Schools Crossing Guard 12 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melville N. Campbell Lucy Dunlop Robertson traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 Is
any injury or other trau 1427 Ives Place, SE, Washington, DC 20003 George L. Bouza/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 26, 2008 1X Burial 2 ☐ Cremation 3 X Removal from State Kensico Cemetery Valhalla, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Breast Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXInknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 DNo director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifish ၉ D45471 July 21, 2008 cause of death (Item 23a) (Type, Print)
1111 Spring Street, #214, Silver Spring, MD 20910 30. Name and address of person who complete Yeheyis Negussie, MD 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 22 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28c per ME g882 8/16/08 TT

State of Maryland? Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 = For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eric J. Bond 2008 900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 corse Chan. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 03/30/1986 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 216-31-5439 22 Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d, Inside City Limits at 1 ☐ Yes 2 No r than "natural", or Items 23a or 28a-f st the Medical Examiner must be notified Director Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with the Hygiene. 1221 Pine Avenue 21037 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrical Worker s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stacy Bond Karen Sparks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Rogers/Mother 1115 Chesapeake Drive, Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 07/21/2008 | Clinton, Maryland 21. Signature of E 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Motor Vehocle Accident with Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off physician and s the burial-trans Due to (or as a consequence of) Box 68760 that the death certificate be Physician/Medical as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has F autopsy performed page certificate 1□ Yes 2. No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Dris 28c. Injury at Work? Certification: Injury CAMI LOST 1 Natural 5 Pending within 24 hours after use.....

To the Funeral Director: After the funeral in by the funeral f July 6, 2008 | 2108 M | 1 = 28e. Pace of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 🕱 No investigation 2 Accident 3☐ Suicide 6 Could not be determined 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4 Homicide street Drive Edgewater, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to he cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 0 31. Date filed (Month, Day, Registrar's Signature State 2 1 2008 JUL Registrar

			State of Maryland / Department	artment of H rtificate of L	lealth and M D <i>eath</i>		giene Reg. No. 2 (008	25120
			Decedent's Name (First, Middle, Last)			2. Date of De		Year	3. Time of Death
	Physicia /Medic	al	BEVERLY BRUW			07	20	08	1141 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 15A Bens Dr.	4b. City, Town, or Annap	Location of Death			y of Death Arund	le1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		212-82-2523 1 M 25 47 Yrs.	Months Days	Hours Will.	11/21/	1960	Mary	land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation				10	0d. Inside City Limits
	Maryl	to	MD Anne Arundel Annapo	lis					1 □Yes 21□No
	or 28a	Oirec	10e. Street and Number	10f. Zip Code			10g. Citizen of		itry?
	s 23a	rall	15A Bens DR.		1403	anifa Wan an Na	USA	Ace - Americ	an Indian
	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Example must be notified	Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of H If Yes, specify Cuba		Rican, etc.)		ack, White, e	etc.
21215-0036	ral', or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Speci	ify: Bla	ick
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		Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle	, Maiden Surna	me)	
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Vine Licensee 2	2. Name and Addre	ss of Facility Har	desty 1	Funeral	Home,	, P.A.
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	law requires that the death certif as been signed by the attending 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause giv	en in Part I.		tobacco use co		he cause of death? bably 4 Unknown
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ta	sician: The certificate irector, pag	Be Co	25. Was case referred to medical		26. Place of Deat	1 □Yes th (Check only	*	1 □Yes	2 LIN6
<u>_</u>	Physical this ce al direct		examiner? 1 Yes 2 No		4 ∐ Nursing H				MER'S HIME
o u	ding Ph h. After th funeral	ion:	27. Manner of Death 1. ■ Natural 5 Pending (Month, Day, Year) 28b. Time of Injury	Wor	ryat k? lYes 2 □ No	28d. Describe	how injury occu	ırred	
Division of Vital	Attending Physician: If death. ector: After this certificial by the funeral director, is	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined building also (Sassific)		1165 2 1110	28f. Location	(Street and Nur	nber or Run	al Route Number,
á	tal or safter al Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)			City or 10	wn, State)		
	Hospi 24 hour Funer tely fill		29a. Certifier (Check only Check only (Check only Check on Check only Check only Check on Ch	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	, and due to th rred at the time	e cause(s) and e, date and place	manner as s e, and due t	stated. to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Medical	one) and manner stated 29b. Signature and title of certifier	29c. Licens			29d. Date sign	ned (Month,	, Day, Year)
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			39 Name and address of person who completed cause of death (Item 23a) (Type	, Pript)	ser the	HLIA	AMA	PAUL	MO21401
	Sta	to.	31. Date filed (Month, Day, Year) 32 Registrar's Signature	U) CFEN	136 11/0	17 -01 -9	1120011	1047	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 1425 PM **Physician** BOYKTON FORSHEE 2002 IERESA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours Min. | Min. | AUS. 30 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 422-70-4684 57 1950 HARTFORD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County NEWS VA 1 XYes 2 □ No NEWPORT Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 23602 U.S.A. SOUTHLAKE 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2XNo 1 ☐ Yes 2 No Specify: WHITE 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. AIRWAY Elementary/Secondary (0-12) College (1-4 or 5+) ATTENDANT EXPRESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ FORSHEE HUNDLEY OPAL _. Z. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEWPORT NEWS, VA 23601 permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trau SOUTHLAKE PLACE 238 ROBERT W. BOYNTON /HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition PENINGUA MEMORIAL PARK 9ULY 16, 2008 1 M Burial 2 ☐ Cremation 3 Removal from State NEWPORT NEWS, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WEYMOUTH FUNERAL HOME NEWPORT NEWS, VA - Navis 1701540 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STATUS EPILEPTIC **Physician** DAYS disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner YEARS TENINGIOMA Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 20 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar physician Division of Vital Records, P.O. Box 68760, ate has been signed by the a page 2 should be detached certificate has funeral director, After this within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu

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filed within 72 hours after thygiene.

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Saltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Certification:

5 Pending investigation Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, 4 - Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed Month. Dav. Year) 29b. Signatu 29c. License number

State Registrar

ADRIAN 31. Date filed (Month, Day, Year) AUG 0 5 2008

PUTTGEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DU 760

600 North Wolfe St, Baltimore, MD, 21287

the Hospital

State of Maryland / Department of Health and Mental Hygiene 25/22 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day 2008 Year **Physician** 21, William July Lester Baker 6:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Living Center Frederick Frederick 8. Date of Birth Mar 11,1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Months Days Hours Min. 219-12-1524 Mary Land 83 Director Usual Residence of Decedent 10b. County Frederick 10c. City, Town or Location Frederick 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Modical Experimer must be notified at Maryland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Dominion Drive, 1-A 21702 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Protection Service Fire Protection 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert John Baker Alice Virginia ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pauline Baker, Wife 2402 Dominion Dr, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖟 Burial 2 ☐ Cremation 3 ☐ Removal from State Grossnickle Church Aug 2, 2008 Myersville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, maryland 21701 21. Signature of Funeral Service Licensee M00706 23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EHD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of). Box 68760, attending physician Physician/Medical the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) P.0. the 9 DUnknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Toll House NEDERIGIC 118 A.KAZMI Year) Day, 2. Registrar's Signature 31. Date filed State Registrar

St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9.00 PM JUL 2008 Kenneth Albert Brown, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL COUNT UNION HOSPITAL OF ZKPN CECIL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 X M 2 □ F Director 219-60-5746 DEC 19, 56 1951 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 22 East Parkway Funeral 21921 United States permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1970— 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth A. Brown, Sr. Thelma Everett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Brown/Wife 22 East Parkway, Elkton, MD 21921 20b. Place of Disposition (Name of cametery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition July 31 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Division or Vital Records, P.O. Box 68760,公 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2∐No 1∐ Yes certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

State

29b. Signature and title of

31. Date filed (Month,

M. A-HAMADEH

Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

ELKTON, MD

29d. Date signed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. N - LIAM ADE+) , 106 BOW STREET,

MID

32. Registrar's Signature

08-05259 Thomas Callan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	3 Callair		1- For State Certificate of Registrar		Reg. No	200	0 2012.
ladia	Physici al Exam	an/	1. Decedent's Name (First, Middle,Last)	31	2. Date of Death Month Day	Year	3. Time of Death 2014 hrs
()	ai Exaili	mei	4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death	July 8, 2008	c. County of Death	
			Union Memorial Hospital	Baltimore			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 53 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	_		hplace (State or Foreign untry)
	any.	~	Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Locati	on			10d. Inside City Limits
	. §	ا <u>-</u>	mo boltimore Boltimor	C			1 Yes 2 No
	th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Cour	ntry?
*	ith the 23a or notific	al Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (Sp	necify Yes or No-	114 Race - Ameri	can Indian, Black,
	leath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
	after d	by F	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:	Yes 2 No specify:		Specify:	nte
	hours "natui	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	it's Usual Occupation (Give kind of vost of working life. DO NOT use ret		Kind of Business/	ndustry
036	IOUC; INID 2 12 13-0000 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. I: If item 27 is marked other than "natural", or items 23a or 28a-fish other traumatic event, the Medical Examiner must be notified at once	Completed	1a Flor	al Designer	K	aimord	is Florist
21215-0036	Definition of the Art 15-0-00 permit. Pages 1 and 2 should be filted with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the IM.	ပ္သိ	17. Father's Name (First, Middle Last)	18.Moher's Name	e (First, Middle, Maide	n Surname)	
212	uld be Menta marke	o Be	19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or	Rural Route Number,	City or Town, State	a, Zip Code)
2	d 2 sho Ith and n 27 is		Larry L. Callan Brother 14304	Cardlastick Ci	+ Monta	bir Ua.	22036
	of Heal		20a. Method Disposition 1 Burial 2 Cremation 3 Removal from State	sition (Name of cemetery, her place)	Date 200	Location - City or	Town, State
Rolfimore	or an er	1	4 Defination 5 Other Specify: 21. Signature of Soneral Service Licensee 22.	Name and Address of Facility	11510816	UYUUI	ICYY. UI
á	permit. Departs Import		Military A. J. J.	ller Funeral Ho	me 300	(sybnsk	is Bliss Va
	Physician		236. Part I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.	he mode of dying, such as cardiac	or respiratory arrest, s	hock, or heart	Approximate Interval Between Onset and
1	Wealca xamine		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dis	ease			Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
		iner	if any, leading to immediate Due to (or as a consequence of):				
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G	ate be shysicia ne buriè	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	гу
707	BOX 68 (e death certifice the attending ped for use as the	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe 4 Pregnant at time of death 5 0	etal death 3 Ectopic pregr ther (Specify)	nancy	Month	Day Year
Š	E death the atte	Physician/	1 Yes 2 No 9 Unknown g Unknown				
	es that the de igned by the detached is	l≥		underlying cause given in Part I.			the cause of death?
-	National Properties of the second properties o	ted			24a. Was an	24b. Were a	utopsy findings available
	e law r e has b	: I =			autopsy performed 1 ✓ Yes 2		completion of cause of
ò	VITAI KEC ysician: The his certificate director, page	ပိ	25. Was case referred to medical	26.Place of Death (Chec			2 110
7.7	DIVISION Of VITAI RECORGS, rat or Attending Physician: The law requirer as after death. **Al Director: After this certificate has been sine in by the funeral director nace 2 should lind in by the funeral director nace 2 should a	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatien			idence 6 Oth	er:
,	n of ding Ph h. After t		27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
	IVISION or Attend after death. Director:	ficati	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre				Rural Route Number, City
Ċ	DIVI pital or ours afte eral Dir	Certification:	Suicide 6 Could not be determined (Specify)		or Town, State)	
	DIVISION Of VITAI RECOIDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commippely filled in the the funeral director, nace 2 should be detached for use as the burial - transi			urred at the time, date and place, ar	nd due to the cause(s)	and manner as sta	ated. the cause(s)
	To the	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		ld. Date signed (M	
	a		70/11/11/17	O.C.M.E.	J	uly 9, 2008	
	8		30. Name and address of person who completed cause of death (Item 23a)*		1001		
			20424	nn Street, Baltimore, MD 2			
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25125 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** July Hanford C. Cook Sr. 19 2008 1:34p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 13tM 2 □ F March 12,1915 Director 214-34-2252 93 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Frederick Woodsboro Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9629 Gravelhill Road 21798 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 12 Board of Education Bus Driver alth and Mental Hygi 27 is marked other r traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ဥ Marsella Hawkins John C. Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other trau 9629 Gravelhill Road, Woodsboro, Maryland 21798 Florence Cook/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Monocacy Church of Bretheran Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 23,08 Rocky Ridge, Maryland 21. Signature of Fyneral 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final astiration Physician disease or condition resulting in death) Weoker nfumbria /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ law requires 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy The perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 131058 21-08 141 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene F. Ashe M.D. 10200 Coppermine Road, Woodsboro, Maryland 21798 31. Date filed (Month, Day, Year) 2 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 25126 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 07 CUTTER 28 2008 1300 ANNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛣 F MARYLÁND Director 08-12-1915 220-10-2398 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination ust be inclined at 1 ☐ Yes 2 ☑ No Director **ALLEGANY** MD FROSTBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20600 HERSICK RD SW 21532 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: 3 ¥ Widowed 4 ☐ Divorced WHITE 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERT GRADY IDA GRADY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA CUTTER <u>20600 HERSICK RD SW FROSTBURG.</u> MD 21532 DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FROSTBURG MEM PARK 08-01-2008 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature of Juneral Service Ligensee 60 W. MAIN STREET FROSTBURG, MD 21532 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART PAILURE **Physician** about 10 days /Medical Examiner CORONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) been signed by the should be detached Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 013STRUTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\bigcap \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division Hospital or Attending within 24 hours after death To the Funeral Director: completely filled in by the

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

Harlit

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sidhu

Heiller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygien ?

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020	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f ehow other treumatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Marrie		Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No No		If Yes, sp 1 ☐ Yes			, Puerto Ric	an, etc.)		k, White, white, white		
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Baltimore, Maryland 21215-0020	y or				Removal from State		Place of Dis cemetery, c Mary's	rematory o	r other pla	ace)	July 26,	2008 I	20c. Location - Kennedy T	ownsh	ip, PA	1
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	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exem	ysician: To the best liner: On the basis and manners	of examina	wledge, de tion and/or	ath occurre investigation	ed at the ton, in my	time, date and opinion, deat	d place, and th occurred	due to the c at the time, d	ause(s) and ma ate and place,	anner as s and due to	tated.	se(s)
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_		10	30. Name and addre	ss of person who	completed cause of	death (Iten	n 23a) (Typ	pe, Print)			1	0.	ń .	1 _ 1	201	10100
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Amend 23a,PII,27,28a-f, perme, g882 8/27/08 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1832 M CHATMAN **BETTY** DELORES 2005 Tin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner George's chever Georges rince dos pita If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Month, Day SEPT 18 5. Social Security Number **Funeral** Days Months 1 □ M 2 □ F NORTH CAROLINA 1944 63 246-64-1527 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1√Yes 2 No Director PRINCE GEORGE'S LANDOVER MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 USA 1818 PALMER PARK ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed by 3 Widowed 4 Divorced d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT PROGRAM ASST. 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental 7 is marked of traumatic even BATMORE HINTON NANNIE WHITTLEY P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1818 PALMER PARK ROAD LANDOVER, MARYLAND 20785 Health a JOSEPH CHATMAN/HUSBAND other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition b permit. Pages
Department of
Important: If It
any injury or o 1 Surial 2 □ Cremation 3 □ Removal from State 7/26/2008 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of duing, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Blood loss complicating atheroscierotic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): cardiovascular disease Examiner Sequentially list conditions Sequentially list conditions, in any, leading look on ininediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No o 9 I Inknown 9 Unknown signed by the Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown been si End-stage renal disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has e 2 s autopsy rector, page 2 The perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2.☐ En/Outpatient 3□ DOA ٩ 1 Inpatient funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Bleeding Trom dialysis Medical Certification: Division or Attending 1/ INatural 5 Pending Injury 1 ☐ Yes 2 ▼ No investigation 7/18/2008 death. unk 2X Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1818 Palmer PArk Rd. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 3

State Registrar

(4)

30. Name and address of person

2 3 2008

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 20, 2008 **Physician** Mildred COHEN 11:29 A м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Min. | March 1, 1916 | Massachusetts <u>Hebrew Home of Greater Washington</u> **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □XF 021-05-6636 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Rockville Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6105 Montrose Road #242 United States Be Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Fine Lena Olem ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12417 Frost Court, Potomac, MD 20854 Inez Grimaldi, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3√☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Sharon Memorial Park: 07/23/08 Sharon, MA 21. Signature of Juner S rvice Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DIE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying caus. (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) 9☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an autopsy performed? Huperten death? 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was c referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Denson M

State Registrar 31. Date filed (Month, Day, Year)

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OCHOON IND 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2 2008

3 Registrar's Signature

ture

Montrose RD Rockielle MD 20852

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:10 P M July 19 2008 Laura Clar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 24, 1925 **Director** 578-36-3743 82 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shevent, the Medical Examinating an aust be molified. 1 1 Yes 2 □ No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 14508 Homecrest Road #511 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 🔯 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛮 No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Denta1 12 should be filed w h and Mental Hygiei r is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tillie "Unknown" ပ Max Altman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) iges 1 and 2 s of Health an If item 27 is 1 Marleen Meier - Daughter 8621 Stableview Court Gaithersburg, MD 20882 permit. Pages 1 and :
Department of Health
Important: If item 27
any Injury or other tr.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns. 7/22/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. Donald 1091 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician and LOVOSEL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760, nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 menths? Month Year 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy perforn certificate 1 □ Yes 1∐Yes 2∐No 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MSON 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7-20-2008 Year **Physician** 8:50 P M CATHERINE DOVE SARAH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CALVERT SOLOMONS SOLOMONS NURSING CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DC 8. Date of Birth (Month, Day, Year) 07-22-1912 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖼 F 578-18-1702 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 FYes 2 □ No Director Prince Frederick Marvland Calvert the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 20678 5880 Ketch Road by Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2∰ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Private Industry 12th 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Windsor James Merchant ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Howard Dove/son Prince Frederick, MD 20678 5880 Ketch Road Department of Health Important: if Item 27 any injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date THE Burial 2 ☐ Cremation 3 ☐ Removal from State 07-25-2008 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Suitland, MD 20746 Jack Cedar Hill FH 4111 PA Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car lice or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue o (s a mequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a c nse r enc- of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy perform rmed2 2 2 No 2 □ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Mannet of Death 28d. Describe how injury occurred After 1 Natural 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the I 29c. License number 29b. Signature and title of certifie.

State Registrar 30. Name and address

who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:55 p July 10, 2008 Donald Dunlap /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year Hours Days Months 1**X** M 2□ F Yrs 91 **Director** 230-03-8269 1917 Washington, DC Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be notified at 1 ☐ Yes 2 🖔 No Director Maryland | Montgomery North Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11208 Joshua Tree Place 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Life Insurance Salesman</u> Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Slater Dunlap Edith Woodhill Twiss ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roberta Dunlap Wolcott-Daughter 5107 Yosemite Drive, Rockville, MD 20853 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 15☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 7-16-2008 Rockville, MD 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852 en 23a. Part 1. Enter the disease, or complications that caused the dilath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atrial Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Diabetes Mellitus Type 2 attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760, Transient Ischemic Attack Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2√∑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No of Funeral Director: A Funeral Director: A letely filled in by the fu 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064615 July 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1355 Piccard Drive, Suite 100, Rockville, MD 20850 Genevieve Wroblewski, 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 22 JUL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Alice Louise D'Amore July 19, 5:25 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care-Potomac Potomac 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months New 1919 057-14-8604 88 York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20902 USA 11022 Amherst Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12 Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Albert Hoke Emma Lolgen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s' if Health a 18 Klimback Court, West Caldwell, NJ 07006 Barbara Lantz/Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Place of Disposition (Name of cemetery, crematory or other place) Pages 1 permit. Pages
Department of
Important: If it
any Injury or o July Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. John Kyle C Muh 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure Exacerbation 2 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Examiner Due to (or as a consequence of): certificate be executed burial-transi Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day Pregnant at time of death the detached o a ☐ Unknown 9 Unknown signed by t t be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>S</u> Atrial Fibrillation, Hypertension, Hypercholesterolemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2**X** No 1 □Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P safter death. I Director; After of in by the funera After Certification: Division 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 11XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 21, 2008 d56136 30. Name and address of person who completed cause of de the (Item 33a) (Type, Print) 5616 Shields Drive, Bethesda, MD 20817 Rebecca Siegel, MD 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2 2008 JUL Registrar

		State of Maryland / Departs Cert	tificate of			Reg. No	20	08 251
Physiciai lical Examin	n/	Decedent's Name (First, Middle,Last) Arthur Clement Dunton			Mon	of Death th Day 23, 2008	Year	3. Time of Death 1309 hrs
		a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location of I	Death		c. County of Dea	th
		Washington County Hospital Emergency Department	ent	Hagerstown	100		Washington	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year If Under 3 Months Days Hours	Mira		Fore	sirthplace (State or eign Maryland
Director	- 1	213-04-3369 1XM 2 F 39	Yrs.	Monars Days Hours	Au	ıg. 27,	1968 °	Country)
		sual Residence of Decedent	Town or Location					10d. Inside City Limits
w an	- 1	,						1 Yes 2 X No
f sho	Þ		gerstown	1 10f. Zip Code		10g C	itizen of What Co	ountry?
Mary r 28a ed at	Director	De. Street and Number						
		11125 Lakeside Dr. Lot 171	6 113 1//2	21740 s Decedent of Hispanic Origin	n? (Specify Y		S.A. I 14. Race - Ame	erican Indian, Black,
ath wi tems st be	Funeral	Nover Married 2 Married Armed Forces?	If Y	es, specify Cuban, Mexican, F	Puerto Rican,	etc.)	White, etc.	
er dez		No Widowed 4 X Divorced If Yes, Give Year	1	Yes 2 X No specify:			Specify: Wh	nite
ural"	3	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden	t's Usual Occupation (Give ki		ne 16b	. Kind of Busines	s/Industry
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during me	ost of working life. DO NOT u	ise retired)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	d d	10	Constr	ruction Worker				tion Company
5-01 ed wi Hygier other	3	7. Father's Name (First, Middle, Last)		18.Mother's	Name (First,	Middle, Maide	en Surname)	
21 be fill mrked vent,	å	Delmar H. Dunton		Mary	y A. C1	<u>atterb</u>	uck Dunt	ton
hould hould nd Me		9a. Informant's Name/Relationship (Type, Print)	T-	g Address (Street and Numb				
MD nd 2 sho alth and m 27 is	1	Mary A. Dunton-mother Oa. Method of Disposition 20b. F	111125 Place of Dispos	Lakeside Dr.	Lot 1.7	7 <u>1 Hage</u> 120	rstown .	MD 21740 or Town, State
STe,			crematory or oth	her place)				
Baltimore, permit. Pages I ar Department of Hee Important: If ite				Ochic CCI j		100		wn, Maryland
Baltimore, MD 212 permit. Pages 1 and 2 should be Department of Health and Ment Important: If item 27 is mark injury or other traumatic ever		1. Signature of Funeral Service Licensee		Name and Address of Facility				
	_	20 Day I Fates the disease of complications that caused the death	Do not enter t	331 Eastern B1	LVU. NC	orth Ha	shock, or heart	Approximate Interva
Physician /Medical		3a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.		no modo or tymg, otom to the			·	Between Onset and Death
⁻xaminer	İ	mmediate Cause (Final disease or condition resulting in death) a. Acute Coronary Throml Due to (or as a consequence of the coronary Thromle)						
		h Atherosclerotic Cardiov		sease				
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	Examiner	cause. Enter Underlying Cause Disease or injury that initiated Supports resulting in death 1 ast Due to (or as a consequence of	of):					
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90, The best of the second of	edical	UNPENDED AMENDED			·			
50, te be exe nysician		F FEMALE: 23c. If yes, outcome of preg	gnancy				23d. Date of deliv	very
1676 tifica ing ph as the	Ju /	3b. Was decedent pregnant in the	2 F	etal death 3 Ectopic	pregnancy	- 1	Month	Day Year
CO 5		4 Pregnant at time of de	eath 5 0	ther (Specify)				
ttenc		1 Vec 2 No.0 Unknown						
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 Mary C. Ellis 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 1 Canla Regional Medical Salisbun 8. Date of Birth (Month, Day, Year) 10/20/1920 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1□M 2 🕇 F Min Months Days Hours Virginia Director 87 227-20-5119 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Event 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 617 Twin Tree Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fil f Health and Mental H Item 27 is marked otl Daniel D. Colcock Lucy Dinwiddie ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4296 Ramblin Rd. Salisbury, Maryland 21804 John Ellis/Son permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other i 20b. Place of Disposition (Name of Vicemetery, crematory or other place Wicomico Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 7/19/2008 Salisbury, Maryland Park 21. Signature of Funeral Service Live Holloway Fuferal Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 Kell YC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Number /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-transit Exami Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 □Yes No O certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown <u>~</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 1 □Ýes 2 1 No of Vital al or Attending Physician: 1 s after death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 63199 8 84 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and E. SHOTE Dr. 614 SALISBUIL Vohra 409esh M.O. gistrar's Signature 31. Date filed (Month Year) State JUL 22 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25136

		- For State	,		Certif	ficate of	Death		_			g. No.	201		010
Physicia al Examin	n/	1. Decedent's Name (First, Middle Daniel	,Last)	Ndi	fon	Ejul	cwa				Date of Deat Month uly 12, 20	Day 008	Year	3. Time of De 1130 hr	
		4a. Facility Name (if not institution University Hospital	, give street and	number)		4	b. City, Tov Baltimo		ocation of	Death		4c. Cou	unty of Deat	h	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last	birthday)	If Under	_	If Under		. Date of Bir	th(MM/DD/\	YYY) 9. Bir Forei	rthplace (State	or
Director	- 1	Unknown	1 X M 2	=	56	Yrs.	Months	Days	Hours	Min.	9-23-	1951	Co	^{gn} Lagos ^{ountry} Nige	ria
b		Usual Residence of Decedent		1.	10a City Ta	own or Location	200							10d. Inside 0	City Limits
w an	l	10a. State 10b. County					OII							1 X Yes	2 No
Maryland 28a-f show any d at once.	흱	MD Montgo	omery		wnea	aton	10f. Zip C	ode			1	0g. Citizen	of What Cou	intry?	
th the Maryland 23a or 28a-f sho notified at once.	Director	10950 Rampart	Way					902				Nig	eria		
with the 18 23a re noti		11. Mantal Status			Ever in U.S.	13. Wa	s Decedent	of Hisp	anic Origi	n? (Speci	fy Yes or No		Race - Ame White, etc.	rican Indian, B	lack,
death r iter	Funeral		1 Ye	forces?	X No		es, specify			rueno Ric	an, etc.)	- 1	12	lack	
raff.	à		orced If Yes, Give		platod\ 1	1 6a. Deceden	Yes 2			ind of work	done		of Business		
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5-0036 ted within 72 tygiene. other than '	Completed			+ y		Auto	Sales	man				Pri	vate		
21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle,						- 1		,		Maiden Sur	name)		1
121 d be fi lental arked	o Be	Steven Ejul 19a. Informant's Name/Relations				10h Mailing	Δddress			na Cu		mber. City o	r Town, Sta	te, Zip Code)	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ř		ıkwa/ Si			10950							0902		_
e, N I and 2 Health item 2		20a. Method of Disposition				ace of Dispos ematory or ot	ition (Name			D	ate	20c. Loca		or Town, State	
nor ages ent of nt: If		1 x Burial 2 Cremation 4 Donation 5 Other Sp		at from Sta	Gate	e of H	eaven			07/2	1/2008	Silv	er Sp	ring, 1	MD (II)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	Ì	21. Signature of Funeral Service) 1									uneral	Home
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Physician Medical		23. Part I. Enter the disease, or failure. List only one cause	★ each line.	*						ardiac or re	-	1000, 0110000	or mount	Between	Onset and eath
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68760, certificate be nding physic se as the buri		23b. Was decedent pregnant in the past 12 months?		ive birth	time of dea	46	etal death		Ectopio	c pregnand	У	M	onth	Day	Year
Box 687 e death certifi the attending ed for use as t	Physician	1 Yes 2 No 9 Uni	rnoum	nknown	une or dea	^{ith} 5 O	ther (Spec	ify)							
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Division tal or Attendi rs after death.	ficat		stigation 28e.	Place of I	njury - At ho	me, farm, stre	eet, factory,	office b	uilding, e	tc. 2	28f. Location or Town		Number or	Rural Route N	lumber, City
Divisi pital or Ati ours after d teral Direct	Certification:	4 V Homicide dete	ermined (Spe		cal Stree						673 Mead	e Village C	Circle, Seve		
the Hos hin 24 h the Fur npfetely	Medical (29a. Certifier 1 Certifying P	hysician: To the	asis of exa	amination ar	ge, death occi nd/or investig	urred at the ation, in my	time, da opinion	ate and pl n, death o	ace, and d ccurred at	lue to the ca the time, da	use(s) and te and place	manner as s e, and due to	stated. the cause(s)	
To To cor	Me	29b. Signature and title of certifi		ner stated			290	. Licens	e number	7		- 1		Month, Day, Ye	ear)
(2)		Mhn Bia	nell, M	D				O.C.	M.E.			July 1	13, 2008		
E CO		30. Name and address of person					Penn St	reet F	Saltimor	re MD 2	21201				
(2)	tate	Melissa Brassell, MD 31. Date filed (Month, Day, Year,			ar's Signatu			. JOI, L		J, WID 2					
S Regis		1111 0 7 2000	Kenn	K	do	No.									

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State Registrar

31. Date filed (Month, Day, Year)

JUL 2 1 2008

32. Registrar's Signature

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Too. State Too. Courty T											8. Date of Birth (Month, Day, June 12,	Year) 9. Bi	rthplace (State or Foreign Country) ryland
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A description of Death Control of Death	The law re	ite has page 2	Complet								autops	an 24b. Were sy pnor t death 2 No 1 \(\sum_{Y} \)	?
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PLAYEEA SLALUM HD 196 TJDLIVE FLEDERICE, KD 21702 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ION OF	ath. r: After this e funeral c		27. Manner of Death	5	28a. Date of Ir (Month, L	njury 28t	b. Time o	f 28c. Inju Wo.	ry at rk?	T		occury)
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31. Date filed (World), Day, Year)	10			//	1				Pririt)	FUEN	= = = = = = = = = = = = = = = = = = = =	~n 17	02
		Sta	ate		h, Day, Year)		strar's Signature)		1 200	GRICE	11) 200	-

			For State Registrar	State of Ma	arylan				ealth ar D <i>eath</i>	nd Me	ntal Hygi ₽∈	iene _{g. No.} 2 (800	25139	9
Ē	Physicia /Medic		1. Decedent's Name (First, Middle David	e, <i>Last)</i> All	.en		Fra	me		2	Date of Death Month July 1	Day	Year 08	3. Time of Death 5:30 P M	
ڗ	Examin Funeral Director	er	4a. Facility Name (If not institution 731 Columbia 5. Social Security Number 219-78-4401	Avenue, Apt 6. Sex 7. Ag	_	last birthday) Yrs.		Cumb er 1 Year	Location of I	d Hrs. 8 Min.	Date of Birth (Month, Day,	Year)		gany Diace (State or Foreign orland	1
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State	Street 12. Was Decedent Armed Forces?	Ever in U.	S. 13.	lumbe 101. Z	edent of Hi ecify Cuba	21502	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	ВІ	f What Cou USA ace - Americal	can Indian,	
21215-0036	d within 72 hours agiene. grenthan "natural", cr the Medical Exar.	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	Year or Dates: 'Year or Dates: 't's Education 'est grade completed) College (1-4or 5)	i+)	16a. Dece	dent's Us kind of w DO NOT	ual Occup	ation during most o	of working		Spec 16b. Kind of Cons		·	
Maryland	uld be file Mental Hy rked othe tic event,	To Be C	17. Father's Name (<i>First, Middle,</i> Thomas	Clifford		Frame			18. Mother's Judy		First, Middle, M Ann			renner	
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Baltimore,	. Pages 1 a tment of Hea tant: If Item Jury or othe		20a. Method of Disposition 1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (5	Specify)	0	Place of Disponentery, cre mberla	matory of nd C	otherplac cemat	ory 07		2008	20c. Location	land,	MD	
Ball	permit Depar Impor any in		21. Signature of Funeral Service	Udamo			404	Decat	ur Str	eet,	Cumbe	rland,		Home, P.A. 21502	
68760,	Physician and Physician and Street Physician and St	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exert Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Metasta Due to (or as b. Due to (or as c. Due to (or as d.	tic a conseq	uence of): uence of):	ance.	0						Onset and Death	
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rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant condit	ions contributing to death b	ut not res	ulting in the u	ınderlying	cause giv	en in Part I.	_				the cause of death? bably 4 ∏Unknown	ı
Vital Records,	The la ate has page 2	Completed									24a. Was a autops perforr 1 Yes	med? 2 💢 No	prior to co death?	opsy findings available ompletion of cause of 2 □ No	•
ō	ath. or: After this be funeral di	ation: To Be	Z LI Addident	Hospital: 1 Inpation 28a. Date of Inju (Month, Dai igation	iry	ER/Outpatie 28b. Time o Injury		28c. Injur Wor	er: 4 🗆 Nurs	sing Home	Check only on e 5 □ Reside d. Describe ho	ence 6 🛣 C		Daughter' (v)Residence	, ,
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director; ocmpletely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 200. Place of Inj building, el	c. (Speci	fy) 					City or Town	n, State)		ral Route Number,	
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	5 with 00 no	2	29b. Signature and title of certification of the second se	N-Qais			9	9c. Licens DO	064167	7		9d. Date sig Ju		, 2008	
	THS Sta	ato.	Noshin Qa	israní, M.D.	, 50	00 Mem		L Ave	nue, (Cumbe	rland,	MD 2	1502		_
	Regist		JUL 1			K.	Chau	1							

		-	For State Registrar		State of N	narylan		rtment of F	lealth and M Death		giene Reg. No	ZIIIX	25140
	Dhysinis		1. Decedent's Name	(First, Middle, Las	st)					2. Date of De Month	ath	v Year	3. Time of Death
	Physicia /Medic		Irene		Larue		Flanig	an-Lockar		July 1	9,	2008	9:30A. M
	Examin	er	4a. Facility Name (If I	not institution, give	e street and numbe	r)			Location of Death			. County of Death	
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	Director		216-20-97	30	□м 2∏ F	90	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 11/02/	1917	Mar	yland
	and w		Usual Residence of E 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	for	MD	Δ11	egany		C	umberland	i				1▼Yes 2 No
	or 28a	Director	10e. Street and Num	ber				10f. Zip Code			10g. Cit	tizen of What Cou	ıntry?
	23a cust be		441 He	nderson					21502			USA	
	er dek Items ner m	Funeral	11. Marital Status1 □ Never Marrie	ad 2 Married	12. Was Deceder	s?	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	 Race - Amer Black, White 	
30	urs aft	by	3 ☐ Widowed 4		1 □ Yes 2 [If Yes, Give Year or Dates	X. 140 5:	'	1 □ Yes 2 汉 No	Specify:			Specify:	hite
2-003p	be filed within 72 hours after death with the Maryland dilygiene. Hygiene do they than "natural" or items 23a or 28a-f show do ther than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	eted	(Special	15. Decedent's Ec	lucation ade completed)		16a. Deced	lent's Usual Occup	ation during most of work	tina	16b. K	(ind of Business/I	
Z	within iene. than "I	Completed	Elementary/Secon		College (1-4c	r 5+)	`life. L	DO NOT use retired	d)	Ü		Retail	
N D	filed v Hygie other t	ပ္ပ	17. Father's Name (A	First, Middle, Last)	<u> </u>			Clerk	18. Mother's Nam	e (First, Middle	, Maider		
Marylan		To Be	Ira		Pete		Anders	son	Ruby			Ros	enmarkle
ary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Nar	, ,		-			and Number or Rui				·
	1 and 1 Health em 27 Ither tr		William 2		gan / Son	20h P	1		Avenue,	Cumber.		, MD 21	502 Fown State
nor	m n -		1 ☐ Burial 2 🍒		Removal from Sta	ie		sition (Name of matory or other place	ory 07/20			mberland	
altimore,	permit. Page Department (Important: If any injury or once.		21. sign sture of Fur) Cuii							Home, P.A.
ñ	an)		Mu	ex l	aams				ur Street			nd, MD	21502
				t failure. List only	plications that caus one cause on each	sed the death line.	n. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (F disease or condition resulting in death)	rinal 1	a. Acu	le Y	ppir	ory t	ulure				
	Examiner				AC	Te ?	xemal) Laile	ero.				
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	ecuter and -trans	Examiner	Sequentially list con if any, leading to imicause. Enter Under Cause (Disease or it that initiated events resulting in death) L.	njury ast	c. Hey	as a consequence	1Ston	, 20					
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89	eath certificate be executed attending physician and for use as the burial-transit	Aedical	IF FFAALF		4.00								
Box	ath cer ttendir or use	an/I	IF FEMALE: 23b. Was decedent in the past 12 i		23c. If yes, outcom 1 ☐ Live birth	n 2 ☐ Feta	Ideath 3	Ectopic pregnanc	у			23d. Date of deli	ivery Day Year
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J.	res that the de signed by the a be detached to		Part II. Other signifi		4 4 7 1		ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	w requires been sign should be	ed by	_ Pial	heles M	ellitas	1				1 🗆	Yes 2	2□No 3□Pr	obably 4 Unknown
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<u>~</u>	: The cate h ; page	Con	CA	+D.	·					perf 1□ Yes	ormed? 2 X N	death?	_
Ž	siclan certifi irector	o Be	25. Was case referr examiner? 1 ☐ Yes 2 ☐		Hospital:	ationt 2	EB/Outpation	nt 3 DOA Ott	26. Place of Dea			0 TO#/0	
o	ding Physician: The lav n. After this certificate has funeral director, page 2		27. Manner of Death	h	28a. Date of		28b. Time o	" 3 DOX	4 LI Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Specury occurred	спу)
Division or	endln ath. or: Aft he fun	atio	1 Natural 2 Accident	5 ☐ Pending investigatio	n	Day reary	Injury		Yes 2 □ No				
Š	or Attencifier death	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	Zoe. Flace of	injury - At he , etc. <i>(Specil</i>		reet, factory, office		28f. Location City or To			ural Route Number,
ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	al Ce	29a. Certifier						ime, date and place				
	he Ho in 24 h he Fu pletely	Medical	(Check only one)	2 Medical Exa	miner: On the basi and manner		ation and/or ir	vestigation, in my	opinion, death occu	rred at the time			
	To t To t	Σ	29b. Signature and	1 m	21.4	MD		29c. Licen	se number			ate signed (Mont	
)	MRSO		20 Name and add						6150		Ju1	y 19,	2008
R	en:08		30. Name and addre		em, M.D.				Cumberlan	id. MD	2150	02	
	Sta		31. Date filed (Mon	th, Day, Year)	32 400	ietrar'e Sign	ature			-,			
	Regist	rar	3	UL 2 1 20	JUO JUO	א ממנו	U /	MACI!					

		FOR	partment of Health and I						
		- Itogratiai	Certificate of Death	Reg. No. 2008 25141 2. Date of Death 3. Time of Death					
Physic	ian	1. Decedent's Name <i>(First, Middle, Last)</i> Jeanne Marie Ferres	0	Month Day Year					
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	Ju1y 30 2008 0645 A [™] 4c. County of Death					
LAGIIII	/	248 Hollingsworth Manor	E1kton	Cecil					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)					
Director		212-38-2447	·	SEPT 17, 1922 Pennsylvania					
yland yow at		10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits					
e Mar ka-fsh tiffled	ctor	Maryland Cecil Elkto	on	1 X Yes 2 □ No					
or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
eath v is 23a must	Funeral	248 Hollingsworth Manor 11. Marital Status 12. Was Decedent Ever in U.S.	21921	United States					
fter d	표	1 □ Never Married 2 □ Married 1 □ Yes 2 NTNo	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl						
ours a	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White					
"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)	16b. Kind of Business/Industry					
within ene.	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	In Her Own Home					
IIIG Z IZ I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)					
aryrar should be and Menta and Menta umarked	TO E	John Marti	Carmel	la Ricardo					
2 sho				ural Route Number, City or Town, State, Zip Code)					
C, E			D2 Delfaire Trace, isposition (Name of crematory or other place)	Date 20c. Location - City or Town, State					
DESILITIOTE, INICITYICILL ALLIN-UOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and other than any order.		Immacu	late	st 1,					
Dallinor permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee	tion Cemetery 2008 22 Name and Address of Facility Hicks Home for Fur	Cherry Hill, MD					
		Donald S. Hicko	103 W. Stockton St	reet, Elkton, MD 21921					
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arrest, Approximate Interval Between Onset and Death					
Physician		Immediate Cause (Final disease or condition resulting in death)	story Jan	me Iday					
/Medical Examiner		Due to (or as a consequence of)	e all oh	and a Sulm. Dry many yo					
	je	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	:	Merce 10001111 (1)					
ate be executed hysician and the burial-transit	Examiner	Cause (Disease or Injury that initiated events	mhalata	2 w/cs					
fou, e be exe sician al e burial-l		resulting in death) Last Due to (or as a consequence of)							
. BOX 08/0U, death certificate be executed e attending physician and d for use as the burial-transit	dical	d							
VI(al Records, P.O. Box od siden: The law requires that the death certifical certificate has been signed by the attending pheretor, page 2 should be detached for use as the cotor, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of delivery					
death death e atte	icia	in the past 12 months? 1 Yes 2 What 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year					
ords, F.C requires that the een signed by the	hys	9 Unknown		200 8144					
ires th	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part i.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ ₩6 3 ☐ Probably 4 ☐ Unknown					
COLOS w requires been sign should be	eted	A Spenters on	9 - 1040						
The law	Completed	Representationes	J. far emilida	autopsy prior to completion of cause of death?					
VITAI Ilclan: T certificat ector, pa	Be Co	25. Was case referred to medical	26. Place of De	1 □ Yes 2 □ No ath (Check only one)					
Or VITA Physician: this certific ral director,	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 ♣ Residence 6 ☐ Other (Specify)					
(7) (7)		1 I I I I I I I I I I I I I I I I I I I	ury Work?	28d. Describe how injury occurred					
JIVISION or Attending after death. Director: After in by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home farm	M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number,					
Jor A after Direc	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	i, allow, lability, office	City or Town, State)					
LIVISIC To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, and manner stated.							
To the within 2 To the complete	Me	29b. Signature and title of certifier, Color of Many 19 Many 1	29c. License number	29d. Date signed (Month, Day, Year)					
,		30. Name and address of person who completed cause of death (Item 23a) (T	vpe. Print)						
		SAYANTILALK PATEL MI) 1235 inguly Ave, Elicton MI) 21921							
	tate	31. Date filed (Month, Day, Year) 32_Registrar's Signature	1.10						
Regis	trar	AUG - 5 2008							

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			For State Registrar		State of Ma	ryland / De (epartment of I Certificate of	Health and N <i>Death</i>	Mental Hyو ا	giene 2 (800	25142	
0.1			1. Decedent's Name (F	First, Middle, Last	")				2. Date of Dea		Year	3. Time of Death	
	Medical ALVIN GOINS								07	17	17 2008 0335 M		
Ex	amin	er	4a. Facility Name (If no	-		A .		or Location of Death			y of Death		
	aval		5. Social Security Number		IERAL HOSP	(In yrs. last birth	Olney day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	•	ice (State or Foreign	
	eral ctor		579-34-623	37 1	(M 2□ F	82 Y	Months Dave	Hours Min.	(Month, Da	y Year) 1925		ngton, DC	
land	4	ł	Usual Residence of Der 10a. State 10	cedent 0b. County		10c. City, Town of	or Location		•		100	d. Inside City Limits	
Mary Ff sh	ped a	ţ	MD M	Montgome	rv	Silve	er Spring					1 <u>x</u> Yes 2 □ No	
h the	Problem	Director	10e. Street and Numbe	er	· ·		10f. Zip Code			10g. Citizen of	What Countr	y?	
th wit	d teu	le l	13401 Dono	aster L	ane		20904			USA	A		
L L L L S-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show	miner m	Funeral	11. Marital Status 1 ☐ Never Married	2 Married	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N	ver in U.S.	 Was Decedent of If Yes, specify Cub □Yes 2x No 		pecify Yes or No Rican, etc.)		ace - Americai ack, White, etc		
hours und	al Exa	od by	3 ☐ Widowed 4 🔀		If Yes, Give Year or Dates:	160 5	Decedent's Usual Occu			Speci 16b. Kind of E	· · · · · · · · · · · · · · · · · · ·		
in 72	n "nat Aedicu	Completed	(Specify of Elementary/Seconda	only highest grad	ication le completed) College (1-4or 5-		Give kind of work done ife. DO NOT use retire	during most of worl	king	TOD. KING OF	ousiness/muu	stry	
d with	the	Som	Elementary/Seconda	lly (0-12)	5 +	Ps	sychologis	t		Gove	ernment	<u> </u>	
be file	d other	Be	17. Father's Name (First	,				18. Mother's Nam	*	Maiden Surna	me)		
2 should and Men is marke	natic	은	Franklin			T		Lucille					
d 2 st th an	Department of result and wenter riggers. Important: If then ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name Alvin E. G				Mailing Address <i>(Stree</i> 3401 Doncas					20904	
E 1 and frem the Health			20a. Method of Disposi		• / 5011		Disposition (Name of crematory or other pla		Date	20c. Location			
Pages ment of ant; If ite			1 X Burial 2 □ C 4 □ Donation 5 □		Removal from State)		eek Cemete	i	22, 200	8 Washi	ington	, DC	
permit. Departn	any inj once.		21. Signature of Funer	al Service Licens	iee A		22. Name and Addr	ress of Facility Jo	ohnson &	Jenkir	ıs Fune	eral Home	
			23a. Part 1. Enter the c	disease, or omp	lical ons that caused ne use on each lin	ne death. Do no				C7 17 17 17 17 17 17 17 17 17 17 17 17 17		Approximate Interval Between	
Physic			Immediate Cause (Final disease or condition										
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ecuted	ransit	Examiner	mai milialeu evenis		c								
te be exe	physician and the burial-transit	a E	resulting in death) Last Due to (or as a consequence of):										
ficate g phys	s the	edical			d								
Attending Physician: The law requires that the death certificate be executed and eath certificate he executed effort. After this certificate has been signed by the attending physician and	for use as	Physician/M	IF FEMALE: 23b. Was decedent pro in the past 12 mon	onths?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	псу			ate of deliver	y Day Year	
t the d	be detached	hysi	1 □Yes 2 No 9 □ Unknown	0	9 ☐ Unknown		U □ Other (opcomy)						
3, 7 ss thal gned I	e det	by P	Part II. Other signification	-	- /	_	,	iven in Part I.	23e. Did t	obacco use co	ntribute to the	cause of death?	
equire	should		<u>ena</u>	Stage	e oll	men	Fig		10	Yes 2 □ No	3∏ Proba	ıbiy 4 Unknown	
The law re the has by		Completed								osy rmed2	prior to com death?	sy findings available pletion of cause of	
ian; T	ral director, page 2	a	25. Was case referred	to medical				26. Place of Dea	1 ☐ Yes	2 No ne)	1 ☐ Yes 2	! LI NO	
hysic his ce	l direc	To B	examiner? 1☐ Yes 2 XNo		Hospital: 1 XInpatie	nt 2 ER/Outp	patient 3 DOA	ther: 4 🗆 Nursing H	ome 5 ☐ Resi	dence 6 □O	ther (Specify)		
ding Ph	9			5 Pending	28a. Date of Injur (Month, Day	y 28b. Tir (Year) Inj	ury Wo		28d. Describe	how injury occu	ırred		
uttend death ctor:	within 24 hours after death. (o the Funeral Director: A xmpletely filled in by the funeral properties)	icat	2 Accident 3 Suicide 6	investigation 6 □Could not be	28e. Place of Inju	rv - At home, farn	M 1 [n, street, factory, office]Yes 2□No	28f Location (Street and Nun	nber or Rural	Route Number,	
tal or A		Certification:	4 Homicide	determined	building, etc		n, outdoor, tactory, onloo		City or To	vn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	risate rvainzoi,	
the Hospital or nin 24 hours afte the Funeral Dir		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the the		Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) At a Motameti, MD 18109 Prince Philip Dr. Diney MD 2083a								/_	/ '	, , , ,			
A	0.		Ata Mota	imedi, 1			nilip Dr	Diney	MD 90	0837			
Re	Sta gistra	te ar	31. Date filed (Month, I	.008°°	SZ. FIEUSTIA	r's Signature	, 						

		•	For State Registrar	state of Marylan		rtificate of L			Reg. No.	2008	25 43	
	Physicis	200						Date of Dea Month	Day	Year	3. Time of Death	
	Physicia /Medic		JACK	July			18, 2008 5:34 P					
	Examin	er	4a. Facility Name (If not institution, give street 9500 Flower Avenue	4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery					
	Funeral		5. Social Security Number 6. Sex		ar If Under 24 Hrs. 8. Date of Birth							
	Director		579-05-6426	1 2 □ F 88	Yrs.	Months Days	Tiours William	May 20,	1920		ngton, DC	
71215-0036 within 72 hours after death with the Maryland ene.	and Dw		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	Mary Ind a	tor	Maryland Montgomery Silver Spring						1 ☐ Yes 2 🖾 No			
	th the	Director	10e. Street and Number 10f. Zip Code							en of What Cou		
	ath will	ral	9500 Flower Avenue				901	-16 -16 - 1 - 1 - 1		ed States		
	er deg	Funeral	11, Walital Otatos	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	14	 Race - Amer Black, White 		
	should be filed within 72 hours after death with the Marylan of Mental Hygiens, are marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than Marifical Examinar must be notified at	by	3 ☐ Widowed 4 ☒ Divorced	1 XYes 2 No 28/4 If Yes, Give 4/28/4 Year or Dates: 12/6/	4 - 45	1∐Yes 2M∏No	Specify:		s	Specify: Cau	casian	
ς Ģ	72 hou natura	eted	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	(Give	dent's Usual Occupa	lurina most of work	ing	16b. Kind	d of Business/fi	ndustry	
ithin 7	vithin ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, ribution Mar			Nev	vspaper		
2	Hyg Hyg ther		17. Father's Name (First, Middle, Last)		2200	1000	18. Mother's Name	e (First, Middle,	Maiden S	urname)		
arylan should be t	lld be fental rked c	To Be	John Henry Grove				Bessie M	ae Ford				
	2 shound In and In is man		19a. Informant's Name/Relationship (Type	. Print)		ng Address (Street a				Town, State, Z	ip Code)	
Σ «	and 2 lealth m 27 in		Robert Ottwell, grands			lower Avenue		pring, MD		01 ation - City or 1	Town State	
ore i	it. Pages 1 and 2 should b irtment of Health and Ment irtant: If item 27 is marked injury or other traumatic e		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rep	novali nom State		osition (Name of matory or other place		3/2008				
	permit, Page Department Important: II any Injury o		4 ☐ Doyation 5 ☐ Other (Specify) 21. Signature of Funeral Service Locasee	Par		emorial Park 2. Name and Addres	<u>'</u>			rille, M		
Ba	Dep any any		11800 New Hampshire Ave., Silver Spring, MD 20901									
		Examiner	23a. Part 1. Enter the dise or complication or complication of shock, or heart failured ist only one	tions that caused the deat cause on each line.	h. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
5	Physician		Immediate Cause (Final disease or condition Respiratory Failure 2 days									
	/Medical Examiner		resulting in death)	Due to (or as a conseq End Stage Ch		hetruetive l	Pulmonary D	isease		İ	2 years	
			Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		DSLIGCTIVE .	dimending b	10000				
	cuted nd ransit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
90,	tificate be executed g physician and as the burial-transit	EX	Due to (or as a consequence of):									
68760,	physi physi s the b	edical	d.									
Box (± 5, €		230. Was decedent pregnant	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy	☐ Ectopic pregnanc	v		2:	3d. Date of del	-	
B	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/N	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)				Month	Day Year	
P.0.	that the de ned by the detached										e contribute to the cause of death?	
ds,	w requires t s been signe should be	Completed by	Paranoid Schizophre	nia				1 🖾	Yes 2□]No 3□Pr	obably 4 Unknown	
S	law req as beel 2 shou	olete						24a. Was		24b. Were au	itopsy findings available completion of cause of	
<u>~</u>	Physician: The la r this certificate ha ral director, page 2	E O							rmed?	death?	2 □No	
/ita	clan: sertific	Be	25. Was case referred to medical examiner? Hospital:						ath (Check only one)			
of	Physic ruthis cral din	<u>ا:</u>	1 ☐ Yes 2 ☑ No	28a. Date of Injury	28b. Time	of 28c, Injur	y at	ome 5 Resi 28d. Describe			cify)	
Division of Vital Records, a or Attending Physician: The law requires t	nding Ph ith. : After th e funeral	tion	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Worl	k̃? Yes 2 □ No					
VIS	of attendated after death Director: A Director: A din by the f	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	iome, farm, st	reet, factory, office	3,513	28f. Location (City or To	Street and wn, State)	d Number or Ri	ural Route Number,	
ō	oital o urs aff eral Di		00 - O - Milian 4 M Contituin - Physici	cian: To the best of my kn	auladga das	th coursed at the ti	mo data and place	and due to the	valise(s)	and manner a	s stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	er: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	rred at the time,	date and	place, and due	e to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of cerlifier			29c. Licens	e number		29d. Date	e signed (Mont	h, Day, Year)	
	10		1 July	MD			D32654		_	July 21	, 2008	
	U		30. Name and ardress of person who com					1 a d O	1022			
	St.	ate	John P. Serlemitsos, M. 31. Date filed (Month, Day, Year)	22 Pagietrar's Sign	aturo		msville, Ma	aryland 2.	1032			
	Regist		JUL 2 2 2008	Marie L	K So	self)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month July **Physician** 20° 2008 LaRue Brown Gosnell 1:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick ler 1 Year | If Under 24 Hrs. Frederick 8. Date of Birth (Month, Day, Year) March 15, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 217-20-6416 84 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√No Carroll Maryland Mt. Airy Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3510 W. Watersville Road 21771 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene, 1 ☐ Yes 2☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than "natu other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th <u>own</u> home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Brown Beulah Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. A, Webster Gosnell <u>21771</u> Husband <u>3510 W. Watersville Road</u> Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery July 23, 2008 Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, PA 212 W. Old Liberty Road Winfield, MD 21784 Approximate Interval Between Onset and Death 23. Pa./1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scock, or heart failure. List only one cause on each line. imm diate Cause (Final disease or condition resulting in death) Cardiovasular disease Physician 44pertensive Geurs /Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Day to for as a consequence of Examiner The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? Month 5 Other (specify) ☐Yes 2 No the 9 Tillnknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural funeral 28a. Date of Injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) or Attending 5 Pending investigation after death.

Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide within 24 hours a To the Funeral [Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cept 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller M.D. 4

aar) 32. Registrar's Signature Dr., Mt. Airy, MD 21771 Ronald E.
31. Date filed (Month, Day, Y 4 Culwell JUL 2 1 State Registrar

State Registrar

31. Date filed (Month, Day, Year)

JUL 2 1 2008

F gistrar's Signature

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 3 /Medical la. Facility Name (If not institution, bive street and number) **Examiner** 4b. City, Town, or Location of Death ON 105016 COUNTE If Under 24 Hrs 8. Date of Birth (Month, Day, Oct. 31 Social Security Number In yrs. last birthday) **Funeral** Sex M 2DF Days Hours 204-28-3860 Yrs. Director Oct. Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, its "medical Evanime" must be mailthed at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland | Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13633 Paradise Dr. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 14 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clergy Lutheran Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Clyde A. Gross ဂ္ Ethel E. Fritz Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Susan Strobl-friend 13637 Paradise Dr. Hagerstown, MD 21742 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State July 29,2008 York, PA 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the offsease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 2 No 5 Other (specify) P.O. □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 🗌 Yes 2 🗌 No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 25. Was case referre d to me 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death Natural After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospina. ... within 24 hours after death.
To the Funeral Director: Aft 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) putraton 31. Date filed (Month, Day, Year,

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland /	Depa Cer	artment o <i>tificate d</i>	f Healt of Dea	th and M eth	lental Hy	giene , _{Reg. No.} C	2008	25147
10	Physici		1. Decedent's Name (First, Middle, La	Odell S.	Gorma	ın	<u> </u>			2. Date of De Month		Year 2008	3. Time of Death 4:32 A.
3	/Medic Examin		4a. Facility Name (If not institution, given				4b. City, Tow	n, or Locat	ion of Death			ounty of Death	
		git	Southern Maryland Hos				Clinton					ce George	
	Funeral Director		5. Social Security Number 6. \$ 214-28-4055	Sex 7. Ag 1 □ M 2 🔀 F	je (In yrs. last b 76	oirthday) Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da March 9,		9. Birth Cou D.C.	place (State or Foreign ntry)
	put		Usual Residence of Decedent 10a. State 10b. County		10c. City, To		cation						10d. Inside City Limits
	Aaryla f shored ed at	or	MD Calvert		Sunder		oduon						1 ☐ Yes 2 ☒ No
	the land	Director	10e. Street and Number		Cando	idild	10f. Zip Coo	le			10g. Citize	en of What Cou	ntry?
	h with		1595 Pushaw Station R	toad				2068	39		USA		
	ems (Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent f Yes, specify (ecify Yes or No Rican, etc.)		I. Race - Ameri Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☒ If Yes, Give Year or Dates:			1 □ Yes 2 🛛			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:	lack
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121	vithin ne.	mple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT use re	tired)		9			
	filed v Hygie ther t		10th 17. Father's Name (First, Middle, Last	·)		Certif	ied Nursin	-		(First, Middle		Retiremen urname)	t Center
lan	id be ental ked o	To Be	•	/ I Holland						_	acheal \		
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship		19	9b. Mailin	ng Address (Str	eet and No	umber or Rura			Town, State, Zi	p Code)
	and 2 ealth n 27 I		Claudette Campbell -	Daughter			Nash Stre						
Baltimore,	iges 1 If of H or oth		20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □	Removal from State	como	of Dispo tery, cren	sition (Name o natory or other	f place)	-	Date	20c. Loca	ation - City or T	own, State
Ē	artmer ortant: injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Sou		Mem. Gar		7/23/2	008	Dunki	rk, MD	
Ba	permii Depar Impor any ir once.		Mady G.	Surell					- 1	Dares Bea	ach Rd.,	Prince Fred	derick, MD 20678
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do	not ente	er the mode of	dying, suc	h as cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	EMIA								Onset and Death
1	/Medical Examiner		Toolang in assum,	11.0	a consequence		UNE						
		ler	Sequentially list conditions, if any, leading to immediate	b. NIDD Due to (or as	a consequence		_0, ~					- 7	
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	· DIAB	ETES	n	ELLITI	20					
90	ie exe ian ar urial-t		resulting in death) Last	•	a consequence	,							
68760,	ficate be executed physician and the burial-transit	edical		d. PNEC	MONI	1+							
O. Box	e death certific he attending p ied for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊅No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea]Ectopic pregna] Other (specif)				23	d. Date of deliving Month	rery Day Year
P.O.	that the		Part II. Other significant conditions	contributing to death t	out not resulting	in the ur	nderlying cause	given in F	art I.	23e. Did 1	tobacco us	e contribute to	the cause of death?
Records,	w requires that the de been signed by the s should be detached	ted by			va c					1 🗆	Yes 2□	No 3□Pro	bably 4 Unknown
Rec	e la has je 2	Completed	,		LEROI					24a. Was auto			opsy findings available ompletion of cause of
ta	ician: Th certificate ector, pag		25. Was case referred to medical	100	SPIRA	1012	7 12	1106		1□ Yes	2 X No	1 ☐ Yes	2 □ No
Γ	di is	To Be	examiner? 1 ☐ Yes 2 DVNo	Hospital: 1 Inpati	ent 2 ER/C	Outpatien	it 3□ DOA	Other:				☐Other (Spec	ify)
n o	iling Ph After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b	. Time of Injury	28c.	Injury at Work?		28d. Describe	how injury	occurred	
Sio	Attending r death. ector; After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be		ium. At homo	form atr		1 🗌 Yes		006 1		Muse have a Dec	al Davida M. anti-an
Division or Vital	after of after of Direct of in by	Certification:	4 ☐ Homicide determined	building, e	tc. (Specify)	iaiii, sii	eet, lactory, on	ice		City or To	wn, State)	Number or Au	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis o and manner st	of examination a	ge, death and/or in	n occurred at the	ne time, da my opinion	te and place, , death occur	and due to the red at the time	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Ž	29b. Signature and title of certifier	_				ense numi			29d. Date	signed (Month	, Day, Year)
)			1/2/somoly	ليسام)4×	2158		JUL	11+,	2002
dR	w 5		30. Name and address of person who SISM OSIA 9	628 Mg.	Moro	Pik	2. Upp	er M	iarlbo.	ro h	AD C	20772	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Regist	rays Signature	J.	Board	وع					

State of Maryland / Department of Health and Mental Hy 1 _ For State

giene 2	0	0	8	2	5		4	-
Reg. No.	_	-	_	60-0		4	•	•

 Physicia /Medic Examine	
Funeral Director	
 <u> </u>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	•	State Registrar			Cer	tificate of	Death		Reg	. No. 2 U	UO	23140
Physicia	ın	1. Decedent's Name (First, Middle LESLIE CARL	e, Last) TON GOBER				- "		Date of Death Month	Day	Year	3. Time of Death
/Medica	al	4a. Facility Name (If not institution				4b. City, Town, o	r Location of		ulyjo	4c. County (of Death	D09 4.M
Examine	er .	WASHINGTON C	-	٩L			GERSTO				HINGT	ON
Funeral		5. Social Security Number 579-70-8212	6. Sex 7. Age		st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y	(ear)	Countr	
Director		Usual Residence of Decedent		55	Yrs. 1/11/1953							IGTON, DC
show	_	10a. State 10b. County		10c. City,	Town or Loc						100	I. Inside City Limits
the Ma	ecto	MD WASH	INGTON		SHARP	SBURG 10f. Zip Code			100	. Citizen of W	/hat Cauntr	1 ☐ Yes 2√ No
h with 1	a Di	3350 HARPERS FI	ERRY ROAD				.782		109	USA	mat Countr	y :
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Evan Inc. rust by notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marr	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give		lf	/as Decedent of H Yes, specify Cuba	Hispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Rica	y Yes or No- an, etc.)		e - America k, White, etc B	
hours	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a Decede	ent's Usual Occup	pation		16	b. Kind of Bus		strv
21215-0036 d within 72 hours aft giene. er than "natural", or , tre Medical Evan	Completed	15. Deceden (Specify only highest Elementary/Secondary (0-12)	college (1-4or 5-		(Give k	ind of work done O NOT use retired SALES	durina most i	of working			RETAI	
ed la la la la la la la la la la la la la	To Be (17. Father's Name (First, Middle, CHARLES T. (,		· · · · · · · · · · · · · · · · · · ·		18. Mother	,	irst, Middle, Ma M. BATT		е)	
, Mar and 2 sho saith and n 27 is m er traum		19a. Informant's Name/Relations LYNNE D. GOBER				Address (Street 2ND ST.						Code)
altimore, mit. Pages 1 ar partment of Hes portant: If item y injury or othe		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation	3 ☐ Removal from State	cen	netery, crem	ition (Name of atory or other place		UGUST Date		c. Location -	•	
Itim		4 □ Donation 5 □ Other (S ₁ 21. Signature of Funeral Service		SMI		Name and Addre		6, 2008	3 I FUNERAL	SMITHSE	•	
Department of the post of the		Charle V	n. Blown		- 1	327 W. KIN					,0, bo	N 021,
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. e.	Do not ente	r the mode of dyir	ng, such as c	cardiac or re	espiratory arres	t,	1	Approximate nterval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Bya	in	Can	cer					7	Onset and Death
Examiner			Due to (or as a	conseque	nce of):							f · '
P #	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce of):							
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a		noo of):							
68760, ifficate be executed g physician and as the burial-transit			Due to (or as a	conseque	rice or).							
x 68760, certificate be executed ding physician and se as the burial-transit	Medical	:= == =	u.									
death death	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the control	2 🗌 Fetal d	leath 3 🗌	Ectopic pregnand Other (specify) _	у			23d. Date Mor	e of deliver nth D	y ∂ay Year
_ 5 p e	by Ph	Part II. Other significant condition	ns contributing to death bu	t not resulti	ing in the und	derlying cause giv	en in Part I.		23e. Did toba	cco use contr	ibute to the	cause of death?
cords w requires been sign should be									1 🗌 Yes	2 🗌 No	3 ☐ Proba	bly 4 Unknown
age de la mage	Completed								24a. Was an autopsy performe	d? p	Vere autops prior to com leath? Yes 2	sy findings available pletion of cause of
of Vital R Physician: The rthis certificate h ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			2□ DOA Oth	or:		heck only one)			
Phy ald grand distribution	ان ا	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur	у 2	R/Outpatient 8b. Time of	28c. Injur	ry at		5 Residence . Describe how			
ending Feath. or: After he funers	atio	1 Accident 5 Pending investig	ation	(Year)	Injury	M 1 🗆	k? Yes 2□N	10				
Division of Vital To the Hospital or Attending Physician: A within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	3 □ Suicide 6 □ Could r 4 □ Homicide determ		ry - At hom . <i>(Specify)</i>	e, farm, stree	et, factory, office		28f.	Location (Stree City or Town, S		er or Rural	Route Number,
Div To the Hospital or within 24 hours after To the Funeral Dire completely filled in k	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examinatio	edge, death on and/or inve	occurred at the ti estigation, in my o	me, date and opinion, deatl	d place, and th occurred a	due to the cau at the time, date	ise(s) and ma e and place, a	nner as sta and due to t	ited. he cause(s)
Vith vith com	Σ	29b. Signature and title of certifier				29c. Licens	se number	12		I. Date signed		
	-	30. Name and address of	who completed a series	oth /lt 2	120) /7:		3 6)		0	7-30		
		30. Name and address of person DR KHALTD WA	Who completed cause of de ASEEM、1126(OWN N	MD 217	740			
State	_	31. Date filed (Month, Day, Year) AUG - 5	32. Registra	r's Signatur		46 >-		- <u> </u>				
Registra DHMH 17 Rev 1/200		vod - 9 (2008	A.	1500 M	39						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hable-Selassie Month Day Vaar 1:38 PM Sebhat 2008 JUly 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Min. Months Days Hours 1 X M 2 □ F Dec 8, 1931 76 Ethiopia None Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 1 Yes 2 □ No Austria Vienna 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Geweygasse 3/6 1190 Austria Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2X No Specify. ⋧ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Director United Nations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hable Selassie Zewdie ည Zewditu Desta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Menber Abrham-Wife Geweygasse 3/6 1190 Vienna, Austria 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-29-2008 Pax Bestattung Vienna, Austria 22. Name and Address of Facility
Murray Funeral Home 21. Signatura of Funeral Service Licensee 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4804 Georgia Ave. N.W. Washington, DC 20011 Immediate Cause (Final disease or condition resulting in death) Acute tubular necrosis Due to (or as a consequence of): Tumor Lysis Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for sels consequence of Hepatoceilvian Carcinoma Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tyes 2X No 1 Tes

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

28a-f show

death with the

the Medical Examiner must be notified at

"natural", or Items 23a or

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 9m 27 Is marked other than "natural", or Ite

permit. Pages 1 and 2 should be filer Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, i

3altimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Director

/Medical

Examine bunial-transit attending physician Physician/Medical the for use as be detached 2 page 2 should Completed certificate has Be 2 Certification:

certificate be executed The taw requires that the death Physician: after death.

Director: After this completely filled in by the funeral Attending 6

within 24 hours a To the Funeral D To the Hospital D)

Of Cours MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 🗷 No

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

(check only

3 Suicide

29a. Certifier

Medical

OMAIR YOUSUF JUL 2 3 2008 32. Registrar's Signature

Hospital:

5 Pending investigation

6 Could not be determined

1 Minpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

RES-000

July 21,2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

Registrar

2 ER/Outpatient

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3 🗆 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 🗌 Yes

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Agnes 11:06 P M Beatrice Hutchinson July 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6801 Bock Road #206 Ft. Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, June 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 M F Maryland 578-38-4220 79 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Directo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 6801 Bock Road #206 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑XNo If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 MMarried 1 ☐ Yes 2003 No Baltimore, Maryland 21215-0036 Specify. Black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) r than College (1-4or 5+) Homemaker In Home f Health and Mental Hygier item 27 Is marked other th other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Campbell Elizabeth Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara J. Hutchinson / Daughter Department of Health Important: If item 27 any injury or other trong once. 3902 Newton Street Colmar Manor, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Remoyal from State Kalas Crematory 7/24/2008 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral gervice Licen 22. Name and Address of FacilityGeorge P. KalasFuneral Home 5160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MALIGNANT NEOPLASM; COLON, unspecified /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2KNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 2 s 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After XXNatural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a 🔀 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H1060665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dona Liskuski MD 9200 Basil Court #200 Landover, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year, State JUL 2 1 2008 Registrar

08-05500 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Madeline Hovaker 2008 25151 Certificate of Death 1- For State Reg. No. teaistrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 17, 2008 2129 hrs **Medical Examiner** Madeline Hovaker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's **Doctors Community Hospital** Cheverly Lanham 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 5. Social Security Number **Funeral** Min. Months Days Hours June 15, 1919 WestwVirginia 89 235-34-0372 Director M 2XF Usual Residence of Deceden 10d. Inside City Limits IOc. City, Town or Location ij 10a State 10h County Prince George's Landover Hills 1 X Yes 2 No Marvland 28a-f show after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 United States 4207 72nd Avenue s 23a or 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White Yes 2 X No specify: 3 X Widowed Give Yea Specify: Divorced saltimore, MD 21215-0036
rmit. Pages 1 and 2 should felled within 72 hours afte partneart of Health and Mould be filed within 72 hours afte portant: If item 27 is marked other than "natural", irry or other traumatic event Þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 17. Father's Name (First, Middle, Last) Enoch Olen Riffee 18.Mother's Name (First, Middle, Maiden Surname) Paulina Grace Hull æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Patricia E. Dickman -daughter 3200 Tremont Avenue Cheverly, Maryland 20785 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/18/2008 Alexandria, Virginia Donation 5 Other Specify Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licen Maryland20705 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Complications of Ischemic Bowel Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED 4b, perME7-22-08, BW, MoCo UNPENDED attending physician or use as the burial The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Yea Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att. page 2 should be detached for 1 Yes 2 ✔ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Unknown Brain tumor, Hypertensive Cardiovascular Disease Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 ✓ Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26. Place of Death (Check only one) 25. Was case referred to medical director, Division of Vital Be examiner? Other; Hospital: Inpatient 2 V ER/Outpatient 3 Residence 6 DOA Nursing Home 5 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Yes 2 No 5 Pending Director: d in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) e Funeral D etely filled i determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME

State

Registrar

29b. Signature and title of certifier

Mary G. Rippie MD.

31. Date filed (Month, Day, Year)

30. Name and address

Registrar's Signature

perso, who compared cause of death (Item 23a)

2008

Deputy Chief Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 18, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Handlin 2305 jenniter Ze /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mayland Hedical Center Bathmore Baltimore City 8. Date of Birth Month, Day, May 16, Social Security Number 6. Se 7. Age (In yrs. last birthday If Under 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Î970 CircTeville, OH 38 571-53-5239 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Ledeal Evan" we must be notified at 1 ☐ Yes 2√☐ No Completed by Funeral Director Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 US 420 Oakton Way Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Arthur Ganley Marilyn Orris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai once. 420 Oakton Way Abingdon, MD 21009 George A. Handlin, Jr. 20b. Place of Disposition (Name of Red energy Grence Rule Press byterian 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wilmington, Delaware Cemetery : 7/25/2008 22. Name and Address of Facility Delaware 19803 21. Signature of Funeral Service Licens 2506 Concord Pike Chandler Funeral Home Wilm Prit1. Enter the disease, or committations that caused the hock, or heart failure. List only one cause on each line. trations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onser and Death mediate Cause (Final disease or condition resulting in death) Hultple **Physician** DERTIFICATION APPROVED BY MEDICAL EMMINES /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as attending for use as use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 1 Yes 2 Unknown 5 Other (specify) 2 🗆 No ed by the Ö 9 Linknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No ٩ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending 1852 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation Motorcycle Crash 7/20/08 28f. Location (Str. t and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Riote 7 at Hill Rd. Abingdon, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number + 20 08 30-Name and address of person who properties of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

lontgomer

2008

31. Date filed (Month, Day, Year)

Street, Balthmore

		a LOI	Department of Health and I Certificate of Death	Mental Hygi Re	ene g. No. 2008	2515
Physici		1. Decedent's Name (First, Middle, Last) Daniel E. Herbst		2. Date of Death Month July	Day Year 16 2008	3. Time of Death 6:43a M
/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
Funeral Director		Northampton Manor Nursing Home 5. Social Security Number 6. Sex 1	Frederick thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan. 2,	Year) 9. Birth	erick place (State or Foreigr intry) ryland
death with the Maryland ms 23a or 28a-f show r must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Frederick Frede	rick			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the	Funeral Director	8104 Ray Smith Road	10f. Zip Code 21704	10	g. Citizen of What Cou United S	,
36 urs after deaf ir, or items	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No if Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	ican Indian,
21215-0036 of within 72 hours af glene. er than "natural", or the Medical Exmi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking	6b. Kind of Business/I	ndustry
that Z be filed ntal Hygi of other event, ti	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		raim
Maryland d 2 should be flie th and Mental Hy 77 Is marked oth traumatic event	ဥ	Raymond Herbst 19a. Informant's Name/Relationship (Type. Print) 19b.	Mary Lea Mailing Address (Street and Number or Re		City or Town, State, Z	ip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemeter	Disposition (Name of y, crematory or other place)	Date 2	Oc. Location - City or 1	Town, State
Dentil. F Departme Importan any injur		21. Signatur Funeral Service Licensee	er Crematory Inc 7/ 22. Name and Address of Facility Stauffer Funeral H 1621 Opossumtown F	lomes P. A	derick, MD	
Physician /Medical		23a. Part1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 23a. Part1. Enter the disease, or complications that caused the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the death. Do not show the	not enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death HONTHS
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death certified attending e attending as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3□Ectopic pregnancy 5□ Other (specify)		23d. Date of deli	very Day Year
requires that the een signed by the hould be detached	þ	Part II. Other significant conditions contributing to death but not resulting in Difference Welli Fus.	the underlying cause given in Part I.		acco use contribute to	
The law rate has b	Completed			24a. Was an autopsy perform	nnior to c	topsy findings available ompletion of cause of
Of VICAL Physician: 1 This certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Other	ath (Check only one	nce 6 🗆 Other (Spec	ifu
JING ling Affer fune	Certification: T	27. Manner of Death 28a. Date of Injury 28b. T		28d. Describe hov		ary)
To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined 28e. Place of injury - At home, far building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge		City or Town,		
the Hos in 24 h ine Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occu	irred at the time, da	ite and place, and due	to the cause(s)
To 1 To 1	Σ	29b. Signature and title of certifier	29c. License number D 6 06 2223	29	d. Date signed <i>(Month</i>	n, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Dr. Praveen Bolarum M.D. 196 Thoma	Type, Print)	ederick.	-	1702
Sta Registr		Cd Date Siled (Month Day Year) CO Design de Cinature	4 Sparle			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month **Physician** HARDY 9, 45AM ELIZABETH GNES 2008 Jul. 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK CITIZENS CARE + Reh. CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2ØF 83 214-34-6132 SEPT3, 1924 Director SNOWHILL, MD Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County a or 28a-f show be notified at FREDERICK 1 ✓ Yes 2 ☐ No MD. FREDERICK Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number BETHEDEN CHURCH RD. 21851 U. S. A. 3316 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 'natural", or Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DOULTRY 12 should be filed within h and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER the TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRIDGETT HUDSON DALE JES316 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1759 CASTLEROCK RD. FREDERICK MO 21701 Department of Health an Important: If Item 27 is any Injury or other tranonce. ALEXANDER HARDY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages : 1 Burial 2 □ Cremation 3 □ Removal from State HUTTS MEM. METH. CH. COM. July 23, 2008 Snowhll Mp. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FUN. Homb 21. Signature of Funeral Service Licenses Rollin 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a consequence of) Examine burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ № Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.0. 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy perform this certificate filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be examiner?
1 | Yes 2 | No

27. Manner of leath
1 | Natural 5
2 | Accident Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After il or Attending Fafter death. 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State

30. Name and address of person who completed ca

KAUFMAN h, Day, Year) L 2 2 2008

ROBER,
31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ST FREDERICK

MARYLAND

death (Item 23a) (Type, Print)

WEST 971+

State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** a^{M} Ju1y 19 2008 4:17 Jacqueline Mae Hernandez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 2801 Manchester Road Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Country) 1 ☐ M 2 ☑ F July 13 1962 MD Director 219-86-2730 46 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2X No iral", or items 23a or 28a-f sh Examiner must be notifled Director Westminster MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21157 USA 2801 Manchester Road Funeral death 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary Ward Boland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f John Slade Elizabeth Owens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is 2801 Manchester Road Westminster, MD <u>Fernando Hernandez, Sr/husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/2272008 Department of h Important; If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Betw such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause. Enter the control of the contr Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 Ø No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy perform 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h. Signat nd title of certifier 29c. License number WIL 15+5 ause of death (Item 22a) (Type, Print) Exten Street Westinister 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Paulette Hazel Hout 07 22 2008 1918 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPTIAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 61 214-46-3532 Director 01/30/1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~- any highly or other traumatic events. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD Cumberland 1 ☐ Yes 2 No Director Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11511 Valley Road, NE 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: Completed by White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Nelson Athey May Hitchins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Growden Terrace, Cumberland, MD Heather L. Pesta / Daughter 20b. Place of Disposition (Name of cernetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Cumberland Crematory 07/24/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ROBABLE ACUTE MYOCARDIAL INFARCTION **Physician** 30 MIN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Luci to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ld be detached for 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1□ Yes 2X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 23, 2008 00033280 10 CUMBERLANDIND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEIGHTS MEDICAL BLOO **UOHNSON** M.D. GUPTA Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 4 2008 Registrar

Physician Kenneth Eugene Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours M 2 □ F 220-58-2688 Director 54 Aug.11,1953 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene.

The start of the st 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at Director Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 21740 526 W. Franklin St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🛣 No Specify. 3 ☐ Widowed ★☆ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other the any Injury or other traumatic event, the once. Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hoffman Francine Fair ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toby Hoffman (Son) 1517 Sherman Ave. Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility estrey Lee laws MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respirationy failure **Physician** disease or condition resulting in death) /Medical Due t (or as a consequence of): Examiner ncepalgrai Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner sician and burial-transit

attending physician for use as the buria

Physician/Medical

Completed

Be

Certification: To

IF FEMALE:

23b. Was decedent pregnage

in the past 12 mon

1 □Yes 2 ☑No

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Acalin and Mental Hygiene Certificate of Death

2. Date of Death

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

Smithsburg, Md.

12525 Bradbury Ave.

23d. Date of delivery

1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown

Month

Washington

U.S.A

14. Race - American Indian, Black, White, etc.

White

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

Maryland

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MPILITUS

1 ☐ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

24a. Was an 1 ☐ Yes 2 410

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne Death

1. Decedent's Name (First, Middle, Last)

5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year) ☐ Could not be determined

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 □Yes 2 □ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 🗌 Suicide

4 Homicide

l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier mul Dellell

H0061117

29d. Date signed (Month, Day, Year) 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francisco A. Daniels, 251 E Antietam Street, Hagerstown MD 21740 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 28b per phys 882 8/5/08 erkficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:47 A M Bruce Edwards Ivins Julv 29 80 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/22/1946 **Funeral** Months Days Hours Min Country 62 Director 280-44-5449 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits "natural", or Items 23a or 28a-f sh ciscal Examiner must be notified 1 Yes 2 □ No Directo Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 Military Road 21.702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) microbiologist U.S. government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Randall Ivins Mary Johnson Knight ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 Military Road, Frederick, MD 21702 Diane Ivins / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Smithsburg Crematory 7/31/2008 Smithsburg, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses yandle & Kull MO1222 106 East Church Street, Frederick, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetjand Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acetaminophen days /Medical Due to (or as a consequence of): Examiner Necrosi acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar or Attending Physician; The law requires that the death certificate be exect Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □ Yes 2 🗆 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 24 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 506) (Month, Day, Year) 1 ☐ Natural 5 Pending 00 6 m Tyleno investigation y26,2008 unknown 1 TYes 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital rederick Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 7/29/08 MDD35106 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) Dr. Myung Hee Nam / 400 West 7th Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 20032. Registrar's Signature State Registrar

30

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Homo Date of Birth (Month, Day, 9 - 2) 10500 NUTSING or Foreign **Funeral** Year) Country) Months Days Min 1 □ M 2 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examing: must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à lack 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fil and Mental H Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip/Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Po 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐Burial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? us certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2∏ No 2. No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 🗌 Yes 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hor To the Fune completely f (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier F-21-08 BARAL Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 3 Market 54. ocom 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 20:44 PM Monty Dwight Johnson Ju₁v 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital oc Cecil County E1kton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 234-70-9591 Sept. 29,1946 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Cecil Rising Sun Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 449 McGrady Road 21911 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after Armed Forces:

1XI Yes 2 \(\text{No}\)

If Yes, Give

Year or Dates: 1968-69 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paint Analyst Automobile Manufacturing 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Johnson Effie Fave Basham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and -ment of Health and permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tri Dorothy A. Johnson / Spouse 449 McGrady Road, Rising Sun, Maryland 20b. Place of Disposition (Name of cemptery, crematory or other place)
Arlington National Cemetery 2008 20c. Location - City or Town, State Arlington, Virginia 22. Name and Address of FacilityCrouch Funeral Home 21. Sign thre of Fu M00510 127 South Main Street, North East, Maryland21901 23a. Ranti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CUTE MYOCAWAL INFAMETION Physician UNKnown /Medical Due to (or as a consequence of): Examiner TRUPE FLISPILLATION LUDATUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ATHERU SCLEILD SIS use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical BIKBBTES IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 7 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation spital or Attendl nours after death. neral Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D007463 Name and address of person who completed cause of death (Item 23a) (Type, Print) NAJERA-138 CATHEDRAL ST ELKTON MD 21921 OTIVA OLANDO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day **JONES** LORETTA 9 12:45 JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE"S LARGO MANOR CARE NURSING HOME 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 😿 F 579-50-7676 **Director** 25 1937 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at Director ty⊡Yes 2 □ No PRINCE GEROGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 23a 20716 921 PLEASANT HILL LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give ō 21215-0036 BLACK 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 🔀 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE RETAIL 11THBaltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked CAREY LOU READY LATIMORE GUNTER ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
532 ORCHARD STREET VIENNA VIRGINIA 22180 19a. Informant's Name/Relationship (Type. Print) f Health a JAMES JONES/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If Ite
any injury or ot 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION HILL BAPT CHURCH 7/26/2008 SALLEY, SOUTH CAROLINA 22. Name and Address of Facility 21. Signature of Funeral Service License J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💥 Unknown BRAIN CANCER STROKE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 💢 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1∐ Yes 2⊠No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number JULY 22, 2008 17 D66658 3) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7500 HANOVER PARKWAY # 101A GREENBELT, MARYLAND 20770 REXFORD A. BABILAH 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

25162

		Registrar		Cer	tilicate of	Deam		Reg. No. 🗀 🔾	00	LOIOL		
Physic		Decedent's Name (First, Middle, Last) Emmett J	Year	3. Time of Death 12:08 A.M								
/Med Exam		4a. Facility Name (If not institution, give s	ames Jenkins treet and number)		4b. City, Town, o	or Location of Death		8, 2008 4c. County		1		
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F		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year		8. Date of Bir			place (State or Foreign		
Funera Directo			M 2□F 50	Yrs.	Months Days	Hours Min.	(Month, Da Septemb	th ly, Year 1957		ntry)		
	-	Usual Residence of Decedent	30				рерсешь	er 15,	wasn	nington,D.C.		
and w		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits		
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vith 1	ij	10e. Street and Number			10f. Zip Code	_		10g. Citizen of \		-		
ath v	2	4174 Suitland Ro			2074			United				
r de tems	Funeral Director		2. Was Decedent Ever in U. Armed Forces? US A1	.S. 13. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No o Rican, etc.))- 14. Rad Biad	ce - Americ ck, White,	can Indian, etc.		
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5-C	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	pation during most of wor	kina	16b. Kind of B				
Me a e figi	宣	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor			_	Hospital		
d wind with the state of the st	Ö	12th grade		Cardi	ac Care	Technicia	ın	Cente	r			
office file	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	,		ne)			
ld by seed seed seed seed seed seed seed see	70 E	Emmett James J	enkins, Sr.			Cece1:	ia Mary	Brook	s			
Maryland 21215-0036 ad 2 should be filed within 72 hours af th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exami	-	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailir	ng Address (Street	t and Number or Ru	ıral Route Numb	er, City or Town,	State, Zir	^{Code)} 22204		
Ind 2 lith a 27 is r tra		Marques Quenton Je	nkins (Son)							n,Virginia		
Te, 1 all tem tem othe		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date	20c. Location -	City or To	own, State		
ages int of		1 Burial 2 Cremation 3 R	emoval from State		matory or other pla	July	25,2008			tenham,		
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		0/ 1////		- 24	R. N. Ho:	ess of Facility rton Comp	any Mor	ticians,	Inc	•		
		Xandaşı (2). Homo						on, D	o.c. 20011		
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	ter the mode of dy	ing, such as cardia	or respiratory a	rrest,		Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition	Seot	1 100	10					Onset and Death		
/Medica		resulting in death)	Due to (or as a conseq	uence of):	1							
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law law as be 2 st	be						24a. Was	an 24b.	Were auto	opsy findings available ompletion of cause of		
The The sage	E O						perf	ormed?	death?	2□No		
Vital F ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Dec	ath (Check only					
Division or Vital Records, P.O. Bc or Attending Physician: The law requires that the death after death. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for u.	To B	examiner?	lospital: 1 ☐ Inpatient 2 ☑	ER/Outpatier	nt 3 DOA Ot	hor		idence 6 □Ot	her (Speci	ifv)		
er thi	1 =	27. Manner of Death	28a. Date of Injury	28b. Time o				how injury occu		•17		
Office th.: After	후	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		onk?]Yes 2∐No						
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affer affer din t	Certification:	building, etc. (Specify) City or Town, State)										
spita ours nerai		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge, deat	th occurred at the	time, date and plac	e, and due to the	cause(s) and m	anner as	stated.		
Division or Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time	, date and place	, and due	to the cause(s)		
To the within 2 To the Complet	Me	29b. Signature and title of certifier	- Juliou		29c. Licen	se number		29d. Date signe	ed (Month	, Day, Year)		
F ≯ F ŏ		/.			NA	1 LIFE	=	07119				
00		L				CUMOS		0 1112	10	5		
0		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	200-1 (1)	- 1	md	06-	7h=		
		Charles Marie 2	(C) (505)	DUTY	WHSK	CORCLU	111100	MA	20	155		
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** Alan Brinkley Killingsworth 2008 ZOOOP M /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Peninsula Regional Medical Center Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 250-32-7878 80 Director 2/14/1928 South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show injury or other traumatic event, the Medical Evaminer must be notified at 1 ☐ Yes 2 XNo Director Virginia Chesterfield Richmond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23236 9910 Adlersmead Ct. USA items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married of Health and Mental Hygiene. Baltimore, Maryland 2∜215-0036 1 ∐Yes 2 🛣 No Specify Navy Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) electrical engineer E.I. DuPont 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ted Killingsworth Bertha Owens ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kitty Killingsworth/wife 9910 Adlersmead Ct., Richmond, VA 23236 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of IImportant: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Westhampton Memorial 7/24/08 Henrico County, VA 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Cio Name and Address of Facility
HOLLOWAY Funeral Home Professional Association Kest/1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial day /Medical Due to (or as a consequence of). Examiner ASWN 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dain to (or as a nonsequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 P No should 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗓 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death.

I Director: A
od in by the fu 1 🗆 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 2008 DO51359

State Registrar

JEE 22 2008

DR-USITA

31. Date filed (Mo

NATESAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

SAUISBURY

MD 27804

700 332992

State of Maryland / Department of Health and Mental Hygiene 0 0 0

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of F	lealth and N Death		iene2 ()	8 0	25164	
ľ	Physicia /Medic		Decedent's Name (First, Middle, Last Helen Hope	Kyle				2. Date of Deat July 2	th 200	8 ^{Year}	3. Time of Death 8:33 P M	
	Examin		4a. Facility Name (If not institution, give				r Location of Death	1	4c. County			
	Funeral		Moran Manor Nu 5. Social Security Number 6. S	rsing Home 7. Age (In yrs	s. last birthday)	If Under 1 Year		8. Date of Birth	Alle	9. Birthp	lace (State or Foreign	
	Director		216-22-7421	□м 2КСХ№ 81	Yrs.	Months Days	Hours Min.	May 15	1927	Mary	Tand	
	pur M		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits	
	Maryla f shore	tor	MD. Allegar		Barton						1 □ Yes XXNo	
	with the 3a or 28a- st be notif	Funeral Director	10e. Street and Number 23711 Middle S	St, SW		10f. Zip Code 215	21	1	10g. Citizen of What Country? United States			
2	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural" or items 23a or 28a-f show if them 27 is marked other than "natural" or items 2 is marked other than "dedical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 □ Never Married 2 ☆ Married 3 □ Widowed 4 □ Divorced	pecify Yes or No- o Rican, etc.)		e - Americ ck, White, whi	etc.					
	n 72 hou "natura ledical Ex	Completed I	15. Decedent's Ec (Specify only highest gra	usiness/Ind	dustry							
7 1 7	d withi giene. r than the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire omemaker	-,		Housew	OLK		
מומ	2 should be filed within and Mental Hygiene. is marked other than ' aumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) Harry Clifton	n Sutherland				ne (First, Middle, I Esther	^{Maiden Surnan} Tasker	ne)		
, Ivial y	and 2 shoualth and No.		19a. Informant's Name/Relationship (Reginald Kyle JR,			ng Address (Street 1 Middle	St, SW,	Barton,			Code) 1521	
5	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Dispo cemetery, crea aurel H	osition (Name of matory or other pla 111 Cemet	ery 08		20c. Location - Barton,			
מוב	permit. Departr Imports any Inju		21. Signature of Funeral Service Licer	yland	l 21562							
ı	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the de one cause on each line.	ath. Do not en	~~	ng, such as cardiad		rest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		- Corre				77-07-03	
	cuted Id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):							
,0070	cate be executed oblysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conse	equence of):							
00	ertifica ing ph e as th	Med	IF FEMALE:									
. DOX	Physician: The law requires that the death certific this certificate has been signed by the attending pal director, page 2 should be detached for use as:	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	☐Ectopic pregnanc☐Other (specify)	у			te of deliventh	ery Day Year	
	that the part of t		Part II. Other significant conditions		_	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?	
colds,	quire; en sigi uld be	ed by	alzheim	ers Remont	747			1 □ Y	es 2□ No	3 ☐ Prol	bably 4 Unknown	
ממט	The law re te has bee age 2 sho	Completed						24a. Was a autop	med?	Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available impletion of cause of	
ō	ilan: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1 Yes ∕ath (Check only of	7	1 🗀 1 es	2 140	
>	hysic his ce il direc	ToE	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2		III 3LI DOA		lome 5□Resid	lence 6 □Oti	ner (Speci	fy)	
2	Ing P		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe h	ow injury occur	rred		
	or Attend after death Director: , in by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	280 Place of injuny - At	home, farm, st]Yes 2□No	28f. Location (S City or Tow		ber or Run	al Route Number,	
-	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical Ce		nysician: To the best of my k niner: On the basis of exami and manner stated.								
	Fo the within Fo the complex	Mec	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date signe	ed (Month,	Day, Year)	
			1 al			22	1244		7/3	0/2	008	
		0	30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print)	,			1		
		ひ	Dr. Jesus Tan, 4	32. Registrar's Sig		a, maryra	110 Z 133Z					
	Sta Regist		31. Date filed (Month, Day, Year)	64	, iaure	Angel & D						

Phys /Me

Exa Fune

Direct permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		State Registrar	Cen	tificate of De	eath	Reg.	No. 2008	25/65
		Decedent's Name (First, Middle, Last)	1. 1	1 11		2. Date of Death	Day Year	3. Time of Death
Physici: Medic/		Benjamin Alexander	Ke	ttelle		July 2	Day Coop	12:17PM
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	1	4c. County of Death	1
		The Johns Hopkins Hospital		Baltimore C	City			
uneral	US -		yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	r) Cou	nplace (State or Foreign intry)
rector		216-63-5461 1XM 2 F	6 Yrs.	Monard Bays	Tiodio Tenti.	March 16	2002 Had	gérstown, MD
3		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	ation				10d. Inside City Limits
sho d at	5							1 ☐ Yes 2X No
28a-f	Director		rantsvill					
or Se no	늅	10e. Street and Number		10f. Zip-Code		10g.	Citizen of What Cou	untry?
s 23a	rai	3707 Chestnut Ridge Rd.		21536		US		
ltem ner m	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?		Vas Decedent of Hisp Yes, specify Cuban,	nanic Ongin? (Spec Mexican, Puerto F	city Yes or No- lican, etc.)	14. Race - Amer Black, White	
amlr	by	1 ★ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1	Yes 2x No	Specify:		Specify: W	nite
tural al E		15. Decedent's Education	16a. Deced	ent's Usual Occupati	on	160	. Kind of Business/	
ledic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		kind of work done du NOT use retired)	ring most of workin	ng		
the h	E	K	Stude	ent		El	ementary	School
othe ent,	Be	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, Mai	den Surname)	
c ev	To E	David Kettelle			Ramona S	Spangler		
s ma umat		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street an	d Number or Rura	l Route Number, C	ty or Town, State, Z	ip Code)
27 is		David Kettelle/Father	3707	Chestnut 1	Ridge Rd.	., Grants	ville, MD	21536
othe		20a. Method of Disposition	20b. Place of Dispo				. Location - City or	
ıt: vo:∓		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		lle Cemete	rvJulv	31, 2008	Grantsvi.	lle, MD
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lisensee		Name and Address				
E E S		D. Low Jaman	J P.	O. Box 27	5, Grants	sville, M	D 21536	
		23a. art 1. Ent. / the disease, or complications that caused the shock, or leart kilure. List only one cause in each line.	death. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arrest,		Approximate Interval Between
sician		Immediate Cause (Final	1 Obs	truction				Onset and Death
edical		resulting in death) a. Due to (or at a co		C OCTON	1 1			
miner		Sequentially list conditions, b	rte Fr	acral O	teotor	111		
	ine	if any, leading to immediate Due to (or as a co	onsequence of):	1				
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ian a		resulting in death) Last Due to (or as a co	onsequence of):	ţ				
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ng p e as	Me.	IF FEMALE:						
tendi or us	6	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
he at	Physicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	e of death 5 L	Other (specify)				
d by detac	문	Part I. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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as b	Completed	Reactive Hirway Diseas	علا			autopsy performed	prior to o	topsy findings available completion of cause of
cate I		25.11				1 ⊠ (Yes 2 □		2 No
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this (raf di	6	1 ☐ Yes 2 No Tospital 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient	3 ☐ DOA Other.	4 Nursing Hon	e 5 Residence 8d. Describe how i		ify)
After	真	1 XNatural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation		Work? M 1 ☐ Ye		.54. 20001130 11011	ngary obbarrou	
ctor:	Ę	3 Suicide 6 Could not be 28e. Place of injury				8f. Location (Stree	t and Number or Ru	ıral Route Number,
d in the	Certification:	4 Homicide determined building, etc. (S	pecify)			City or Town, St	ate)	
y fille		29a. Certifier 1 Certifying Physician: To the best of my	y knowledge, death	occurred at the time	, date and place, a	and due to the caus	e(s) and manner as	stated.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(check only one) 2 Medical Examiner: On the basis of examiner stated	ımınation and/or inv	estigation, in my opir	nion, death occurre	ed at the time, date	and place, and due	e to the cause(s)
10 th	Ž	29b. Signature and title of certifier		29c. License n	umber ·	29d.	Date signed (Month	i, Day, Year)
		Jan Wista A	1,0	RES	-000	, \	July 2	1 200h
	4	30. Name and add ess of person who completed cause of death	h (Item 23a) (Type,	Print)			(/	,
		Jason Custe			600 N	orth Wolfe	St, Baltimo	ore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	and s				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar 25166 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 18,2008 5:35am Jane Kromer Kean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 5310 Yorktown RD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8,1914 9. Birthplace (State or Foreign Social Security Number 577–18–2905 6. Sex **Funeral** 1 □ M 2 X F Months Days Hours Min. Georgia Director 94 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or items 23a or 28a-f showing the monthlest at 1 Yes 2 □ No Bethesda MD Montgomery Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5310 Yorktown Rd 20816 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exportant intest inset once. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Financial Officer Elementary/Secondary (0-12) College (1-4or 5+) Treatment Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane S. Wainwright Leon B. Kromer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annesley K. Schmidt /Daughter 5015 Smallwood Dr. Bethesda, MD 20816 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/25/2008 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gauss on each line. 5130 Wisconsin Ave, N.W. Washington DC 20016 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 Weeks Pneumonia /Medical Due to (or as a consequence of): Examiner 4 Months Amiodarone Pulmonary Toxicity Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Years Atrial Fibrillation The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Congestive Heart Failure cate has been signated by page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 21 No 1 ☐ Yes 2² No 1 ☐ Yes spital or Attending Physician: 1 hours after death. ineral Director: After this certifica y filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1∐Yes 2☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1√ Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number July 18, 2008 D32033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter G. Hamm MD 5530 Wisconsin Ave. Chevy Chase, MD 20815 gistrar's Signature 31. Date filed (Month, Day, Year) State 2008

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Registrar

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State of Maryland / Department of Health and Mental Hygiene -Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2000 **Physician** Kendall Nancy Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Forei Months | Days | Hours | Min. | August 23, 1931 | Pennsylvania 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ X F 76 220-26-6179 Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinations to the filled at 1 XiYes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 333 Mill Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othwarn injury or other traumatic event, Be Sr. Betty Oliver Hay Catherine Lookabaugh Harry ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Kendall Son 11550 Burkett Lane, Greencastle, Pa. 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Williamsport, Maryland Greenlawn Memorial Pk. 07-28-08 4 Donation 5 Dother (Specify) Andrew K Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licensee R. hoel Braa Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Menning Physician /Medical Due to (or as a consequence of): Examiner evente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Palmonary Disease Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-trar P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖽 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy death? 1 ☐ Yes 2 ☐ No certificate 1 □Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Propatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 2323 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Muhanmad waseem, M.D. 1126 OPALCOUT, HAGERSTOWN, MD 21740 5H-Z 31. Date filed (Month, Day, Year) 5 2008 strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

)	8+	3	30. Name and address of person who Harjit S. S			pe, Print)	D26907		July 25,	2008
ì	_		•	Thur		1	D26907		Julv 25	2008
	0 = 0 5	2	29b. Signature and title of certifier	-1 - 11 -		29c. Licens		29	d. Date signed (Mont	n, Day, Year)
	the Hos hin 24 hi the Fun	Medical	(Check only 2 Medical Examone)	miner: On the basis of e	examination and/o	r investigation, in my o	opinion, death occur	red at the time, da	ate and place, and due	e to the cause(s)
2	spital or A		4 Homicide determined		(Specify)			City or Town		·
JIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by	e 280 Place of injur		ry Wor	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
r Vital	hysicia nis certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpa	tient 3 DOA Oth	26. Place of Deather: 4 X Nursing Ho		nce 6 □Other (Spe	cify)
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Is, P.O	res that tigned by	by Ph	Part II. Other significant conditions of	contributing to death but					acco use contribute to	
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		1	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □		20b. Place of Di	sposition (Name of crematory or other place	ce)	Date 2	20c. Location - City or	Town, State
Mary	2 Salar al	F	19a. Informant's Name/Relationship (Debra K. Kienhofe						City or Town, State, 2	Zip Code)
and	be ad a	To Be C	17. Father's Name (First, Middle, Last, Alfred	Joseph	Kienho	ofer, Sr.	18. Mother's Name France			
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တ	after dea or items miner m	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Married	12. Was Decedent Ev Armed Forces? 1 Xes 2 No If Yes, Give		 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No 		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ral Dire	10e. Street and Number 925 Frederick	c Street		10f. Zip Code	21502	10	og. Citizen of What Co U	SA
	ne Maryla 8a-f sho stified at	Director	MD Alle	egany	-	Cumberland				1 X Yes 2 □ No
L	Director		216-22-5322 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o			02/02/1	927 Mar	'yland 10d. Inside City Limits
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	Physicia		 Decedent's Name (First, Middle, La Alfred 	_{st)} Joseph	K	ienhofer,	Jr.	2. Date of Death Month July 24	Day Year	3. Time of Death 3:00 P
			For State Registrar			ertificate of	Death		eg. No 2008	

		ľ	For State Registrar	State of Marylai	-	rtificate of D			Reg. No.	2008	25169)
	Physicia	an	1. Decedent's Name (First, Middle, Last) Pauline May Kimme	-1				2. Date of Dea Month 7-29-20		Year	3. Time of Death 10:32 A M	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or Lo	ocation of Death	1-45-4		County of Death	10.32 A	-
ne.			Northhampton Manor	Health Care		Frederic			Frederick			
١	Funeral Director		217 20 7425	м 2½ F 7. Age (In yrs 91			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Pa 5-1-1	1 1 2 2 ar)	9. Birthp Cour	place (State or Foreign htry) MD	
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39	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the fredient Experient must be maithed at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2∑No	Mexican, Puerto Specify:	Rican, etc.)		Black, White,		
Maryland 21215-0036	72 hou natura lical E	Completed by	15. Decedent's Educ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin								
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¶ar√	2 should I and Men Is marke raumatic		19a. Informant's Name/Relationship (Typ	•	1	ng Address (Street and					Code)	
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E E	Pages 'nent of hant of hant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of natory or other place) ivet Cem.	 			derick,		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Serve License	rd P.A.	F.H.	100						
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a de la company	Physician	8	Immediate Cause (Final disease or condition	9742953.39							Onset and Death	
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Box	eath certification attending processes for use as		IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome of pregn	ancy				2	3d. Date of delive	ery	
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ord	w require been signature should b							1 🗆 Y	es 2	No 3□ Prob	oably 4 Unknown	
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<u>o</u>	△ + ⊠	Di:T	27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Injury a Work?	1 ,	28d. Describe h			<i>17</i>	_
Sio	Attending Phys ar death. ector: After this coty the funeral direction.	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 □Ye	s 2 No					_
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	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my opir	, date and place, nion, death occur	and due to the red at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)	
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			1 hos			D 5	1643		7-2	9-2008		
			30. Name and address of person who cor Dr. Hiren N. Shah				Mozer-1	and 2170	11			_
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature _		, raryta	ALIC 21/(<i>)</i>			-
			AUI3 = 5 7008	March Mil	Allen auch							

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_			For State Registrar	State o	f Marylar	nd / Depa <i>Ce</i>	artment of rtificate o	Health a f Death	and N	fental Hy	/giene Reg. No.	2008	3 25170
	Physici /Medi	cal		VELACE	mb o et		4.00.7		1.0	2. Date of Domestin	1, 20		3. Time of Death 12:50 PM
9	Examir Funeral	ner	4a. Facility Name (If not înstitution SUBURBAN HOSPI 5. Social Security Number	-	7. Age (In yrs.	last birthday)	4b. City, Town, BETHES	DA		8. Date of Bi	MO	NTGOME	RY
	Director		223-40-7746 Usual Residence of Decedent 10a. State 10b. County	1□M 242F	81	Yrs.	Months Day	s Hours	Min,	01-13-	1927	Pit	tsylvania, VA
	oth with the Marylan 23a or 28a-f show	Director	Maryland Montg	omery	100. 01	-	vy Chase				10g. Citiz	zen of What C	1 d Yes 2 □ No
0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Ezan increment be notified at	by Funeral	8700 Jones Mil 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece Armed Fo	2 ; [∏ No ⁄e		Was Decedent of If Yes, specify Cu 1 □Yes 2分N			ecify Yes or N Rican, etc.)	0- 1	USA 4- Race - Ame Black, White	erican Indian, le, etc. ack
121215-	led within 72 h lygjene, her than "natu nt, tre Medica	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12th	college (1	-4or 5+)	16a. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use retii	e during most red)			Fede		vernment
ıryland	should be fill and Mental H marked ott	To Be	17. Father's Name (First, Middle, Henry Lovelac 19a. Informant's Name/Relations	e		10h Maiti	ng Address (Stree	E11	a Wa				7:- Co.(1)
altimore, Maryland 21215-0036	permit, Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene, Important: If Item 27 is marked other than "natural", or items any Injury or other traumatic event, trainedical Evantine maone.		Robert J. Lovel 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	ace/son	State	1000 Place of Disponentery, cres	Daleview Dalion (Name of matory or other pi emorial	Dr.	Silv	ver Spr	ing,M	D cation - City or	
Ball	permit Depart Import any Inj		21. Signature of Funeral Service	Licensee	MOIZ	16	^{2. Name and Add} edar Hil	•		PA Ave	. Su	iitland	,MD 20746
9	Physician /Medical Examiner	76	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. RECU	ach lîne. RRENT F or as a conseq	PNEUMON juence of):			cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death 10 Days
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (ATHER	or as a conseq	uence of): DTIC CA	ARDIOVASO		DISE	ASE			Years
P.O. Box 6	at the death certific by the aftending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/mths? 1 □ Yes 2 ☑ No 9 □ Unknown		oirth 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnal	ncy			2:	3d. Date of de Month	olivery Day Year
	w requires that been signed I should be det	ρ	Part II. Other significant condition SEPSIS, RESPIR	ns contributing to de	LURE,	ulting in the u	nderlying cause g IA TOTAL	iven in Part I. CARE,			tobacco us Yes 2 ₽		o the cause of death?
al Records,	ilclan: The law re certificate has be ector, page 2 sho	Completed	HTN, CONGESTIV	/E HEART F	FAILURE					24a. Was auto perfo 1 ∐Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 You 27. Mann of Death 1 V Natural 5 Pending investig 2 Accident investig 3 Suicide 6 Could of determined to the could be determined.	28a. Date of (Month ation of be ped 28e. Place	npatient 2 of Injury h, Day, Year) of Injury - At hong, etc. (Specification)	28b. Time of Injury	28c. Inj	ther: 4 □ Nur ury at ork? □Yes 2 □ N	rsing Ho	me 5 Res 28d. Describe 28f. Location (City or To	idence 6 how injury	occurred	ural Route Number,
	Hospital of 24 hours at Funeral D etely filled i	Medical Ce	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the Examiner: On the ba	asis of examina	owledge, death	h occurred at the vestigation, in my	time, date and	d place,	and due to the	e cause(s) , date and	and manner a	us stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	jamá	md a	<i>N</i>	29c. Licer D533	nse number			29d. Date	e signed (Mon.	_
	6		30. Name and address of person was Rajan, Shyamsu	ndar, MD	9801	Georgi	Print) a Avenue	Suit	e 11	l7 Si1	ver S	Spring,	MD 20902
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	Stew 32. Re	egistrar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 17, 2008 4c. County of Death Elizabeth Whaley Leonard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RebabaNursingCtr Wicomico Dali's bure If Under 1 Year | If Under 24 Hrs. | 6 Date of Birth (Month, Day, Year, 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Feb. Maryland Director 218-24-4070 83 11, 1925 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural", or Items 23a 113 Flower Street Funeral 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 14. Bace 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 K No þ Specify. Specify: 3 X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other t any Injury or other traumatic event, in once. laborer Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Whalev ဂ္ Bessie Showell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston Whaley/brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

114 Schoolfield Street - Berlin, Maryland 21811

20c. Location - City or Town, S 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Paul UMC Cemetery July 24, 2008 Berlin, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHPAEL, P.A. 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** pay resulting in death) /Medical Due to (or as a consequence of): Examiner Bran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last the burlat-tran Due to (or as a consequence of) the attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 25. Was case referred to medical Be 26. Place of Death Check onl one 1 ☐ Yes 2 ☐ 1√0 Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕒 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

PONQUE

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medic Examin
Funeral Director
D .

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified a once.

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registr <i>a</i> r			Cei	rtificate d	of Death		Re	g. No. C	108	2311
	1. Decedent's Name (First, Midd	le, Last)						ate of Death		Year	3. Time of Deal
an al	ALTA				LEHR		07		23	08	2210
	4a. Facility Name (If not institution	n, give street and nu	umber)		4b. City, Tow	n, or Location of I	Death		4c. Cour	nty of Death	1
	WMHS BRADD			14 b : 46 do . \	CUM If Under 1 Ye	BERLAND ar I If Under 24	Hrs lo D	ate of Birth	AL	LEGAN 9 Birth	Y place (State or For
	5. Social Security Number 215-26-7621	6. Sex 1 □ M 2 耳 F	7. Age (In yrs. 79	<i>iast birtnday)</i> Υrs.			Min. (N	fonth, Day,	Year) 08, 1928	Cou	Maryland
	Usual Residence of Decedent										
	10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation						10d. Inside City Lir 1 Yes 2 □
cto	Maryland	Allegany				Lonaco	ning	111.			1017
Director	10e. Street and Number		10f. Zip Co		3	10	g. Citizen o		SA		
Funeral		Pershing Stre	edent Ever in U.	6 12	Nas Dagodant	of Hienanic Origin		es or No-	14 B		ican Indian,
E	11. Marital Status 1 □ Never Married 2 ☑ Mar	Armed F		1		of Hispanic Origir Cuban, Mexican, F	Puerto Rican	etc.)		lack, White,	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1⊡Yes 2💢	No Specify:			Spec	cify:	White
Be Completed	15. Deceder	nt's Education est grade completed;)	16a. Dece	dent's Usual O	cupation one <i>during most</i> o	f workina	1	6b. Kind of	Business/Ir	ndustry
du	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use re	tired)				н	ome
ပိ	12		0			Homemak	Name (Firs	t Middle M	laiden Surn		Onic
	17. Father's Name (First, Middle,	Holmes	Shreve			To. Wiodier	rvanic (1110		ace Swe		
၉	19a. Informant's Name/Relations		Sineve	19h Mailii	ng Address (St	reet and Number	or Rural Rou	te Number,	City or Tov	vn, State, Zi	ip Code)
		Lehr - Husban	d			Pershing St					
t	20a. Method of Disposition			Place of Dispo	sition (Name o	f place)	Date	2	20c. Locatio	n - City or T	own, State
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		perland Crematory July 25, 2008 Cumberland, Maryland						
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Fu										
	Brandi	Lluhal	M			East Main			aconing	MD 21	1539
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Immediate Cause (Final	mva	rardia	linto	1+c+100						Onset and Death
	resulting in death)										
	Due to (or as a consequence of): attended to the catalous sculat disease 4 years										4 years
ē.	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
Exa	resulting in death) Last Due to (or as a consequence of):										
Medical		d									
Jed	IE ECMALE.										
	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Feta		☐ Ectopic preg	nancy				Date of deli [,] Month	very Day Year
Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No		gnant at time of o		Other (specif		-			MOTILIT	Day Tear
	9 Unknown				-	aiven in Bort I	1	2a Did toh	acco use to	ontribute to	the cause of death
6	Part II. Other significant conditi	ions contributing to t	death but not res	ulung in the t	nderlying caus	given in Fait i.		1 □ Ye	/		obably 4 Unkn
77							- L				
je							2	4a. Was ar autops	y .	b. Were aut prior to c death?	topsy findings avail completion of cause
npletec		***						perform			
								perform ☐Yes 2	No	1 ∐ Yes	2 🗆 No
Be	25. Was case referred to medica examiner?	Hospital:)			Othor	f Death (Che	perform □Yes 2 eck only one	No No		
å	examiner? 1 Yes 2 No	Hospital: 1 🔽		ER/Outpatie		Other: 4 Nurs	f Death <i>(Che</i>	perform ☐Yes 2 eck only one ☐ Reside	No No	Other (Spec	
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State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Leila Viola LEIGH 8:40 p. M Ju1y 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13421 Greencastle Pike Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 216-80-1986 1 □ M 2 🖾 F 94 19,1914 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13421 Greencastle Pike 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ģ Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife her own home Ith and Mental Hygier
7 is marked other th
traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Henry Long Edna Viola Irvin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Nott - daughter 13421 Greencastle, Pike, Hagerstown, Md. 21740 Item 27 r other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 듄 Department of Important: If It any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 7/26/08 4 Donation 5 Dother (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the reath. To not enter the mode of dying, such as # rdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nomone /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any teacing to kname liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dira to for as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 1 ☐ Yes 2 NO 1 □Yes Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to med examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 HN0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manne 10 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Death 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier DW7898 ANDRAGE 350 HILL ST. HAGERSTOWN MD21740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCISC

State Registrar

31. Date filed (Month, Day, Year)

State of Marvland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear Edward Michael Lee July 17 2008 5:40 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 29, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours **1XX**M 2□ F 86 Yrs. Director 1921 Őhio 292-16-0067 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Maryland Montgomery Silver Spring Director 1 ☐ Yes 2\No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 607 Cloverfield Place 20910 U.S.A. Funeral ral", or Items 2 12. Was Decedent Ever in U.S. Armed Forces?

1/2/2/es 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XXMarried Maryland 21215-0036 ģ 1 ☐ Yes **2**CXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II "natural", Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " ent, the Med Elementary/Secondary (0-12) College (1-4or 5+) Statistician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant; If item 27 Is marked out Be Orville Lee Mary Sutton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth M. Lee/daughter 607 Cloverfield Place Silver Spring, MD item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If i any Injury or once, St. Anne's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/19/2008 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Whehe 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) DAYS Due to (or as a consequence of): /Medical Examiner PSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9☐Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY FV & 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was ...
autopsy
performed?
Yes 2 No page 2 certificate or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 7/17/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, Suite 220 Silver Spring, MD 20902 Dr. S K Gupta 31. Date filed (Month, Day, Year) State JUL 2 1 2008 Registrar

Amended #18, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per fd, 07/14/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - For State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0020 A $^{\text{M}}$ 07 11 08 ALICE LANDIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WHMS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCT • 19,1952 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 V F 55 219-56-9808 WEST VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director CUMBERLAND MD ALLEGANY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21502 333 FORT HILL AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: If Yes, Give Year or Dates: ð WHITE 3 XWidowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the SUPERVISOR CLEANING SERVICE 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname)
LALLA
LILA-SIESE - SCIESE 17. Father's Name (First, Middle, Last) Be GEORGE HARMON HANSFORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE LEASE / DAUGHTER 333 FORT HILL AVENUE, CUMBERLAND, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 07/15/2008 CUMBERLAND, MD 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, 21. Signature of Funeral Jurvice Licens WERLING 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months Gastria arcinoma /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) iner the death certificate be executed Exam g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending plant IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4⊡Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9☐Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2□ No 2 No 1□ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Inpatient this 28b. Time of 27. Manner of Death 28a, Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f To the Hospital or nows

29a. Certifier

(Check only one)

30. Name and address of

31. Date filed (Month, Day,

JUL 1

29b. Signature and tifle of certifier

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2008

State

Medical

Registrar

person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1000 33280

umberland, Maryland

29d. Date signed (Month, Day, Year)

Amended #20c,		nt in Black Indelible Ink		
per fd, 07/18 Allegany Co.	State of Ma	aryland / Department of I 8/15/08	Health and Mental Hy Death	giene Reg. No. 2008 25176
Dhysisian	Decedent's Name (First, Middle, Last)		2. Date of De Month	
. Physician /Medical	Thomas	Lechliter	07	15 08 1025 ^M
Examiner	4a. Facility Name (If not institution, give street and number)		or Location of Death	4c. County of Death
Funeral	WMHS Braddock Campus 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of Bird	th 9. Birthplace (State or Foreign
Director	5. Social Security Number 6. Sex 7. Ag 129–32–7101	72 Yrs. Months Days	Hours Min. (Month, Da JAN • 25	, 1936 WEST VIRGINIA
and *	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. inside City Limits
Maryla f sho led at	WV MINERAL	RIDGELEY		1 ☐ Yes 2 🏋 No
r 28a- notif	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
th with	ROUTE 3, BOX 356	2675	3	U.S.A.
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show slical Examiner must be notified at eted by Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes or No oan, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
D36 urs afte salt; or l	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 YDivorced Year or Dates:	No 159-162 1□Yes 2☒No	Specify:	Specify: WHITE
2-bou 2-bou latura ical E	15. Decedent's Education	16a Decedent's Usual Occu	pation	16b. Kind of Business/Industry
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fin Medical Examiner must be notified at once. To Be Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5)	5+) Give kind of work done life. DO NOT use retire	e during most of working ed) RKER	1) Celanese Fibers 2) VAlley Protein
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far)	19a. Informant's Name/Relationship (Type. Print)		t and Number or Rural Route Numb	
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MOF Pages tent of i	1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) GINEVAN CEMETERY	07/19/2008	20c. Location - City or Town, State PAW PAW PW, WV
Baltii permit. 4 Departm Importar any Inju	21. Signature of Funeral St. rvice Liven, ee	22. Name and Addr	ess of Facility	
Bal permi Depa Impo any ir	young of upchine	202 GRE	H FUNÉRAL HOME, ENE STREET, CUMB	ERLAND, MD 21502
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Physician /Medical	resulting in death)	DKIC ENCEPTY	AZOPATHY EST	8 DAYS
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To the Hosp within 24 hou To the Fune completely fi	one) and manner st	ated.	nse number	29d. Date signed (Month, Day, Year)
and and				
1/+	30. Name and address of person who completed cause of c	death (Item 23a) (Type, Print)	706	July 15,2008
NLS	William Lamm m.b.	100 Seton Brive	, Cumberland,	MB 21502
State Registrar	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature		

Orlando Chave Z Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25177

		1- For State Registrar		Ce	ertifica	ate of I	Death			F	eg. No.	200	3 0	2011
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		4a. Facility Name (if not institution	n, give street and n	umber)		4t	. City, Town, or Lo	ocation of	Death		4c. Cou	unty of Dea	th	
		Sligo Creek N of Pine	y Branch				Wheaton				Mon	tgomery		DI
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birt	hday)	If Under 1 Year	If Under	24Hrs.	8. Date of Bi	rth(MM/DD/\			(State or Foreign
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any		10a. State 10b. County		10c. Cit	y, Town	or Location	n						10d. Ir	nside City Limits
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21215-0036 build be filed within 72 hours after Mental Hygiene. marked other than "natural"; ic event, the Medical Examiner?	Be	Lazaro Mendo	za					Hil	lđa (Chavez				
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ord w rec us bee	Per									24a. Was	psy	prior to	o complet	indings available ion of cause of
eC he la ate ha	등										ormed?	death1 1 ✓		2 No
tal Reco ian: The law certificate has	O	25. Was case referred to medica	ı				26.Place o	of Death (Check or	nly one)				
/ita /sicia nis ce direc	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/O	utpatient	3 DOA C	ther ₄	Nursing	Home 5	Residence	6 🗸 Oth	ner: Scene	9
of of g Ph g Ph fiter t	1. To	27. Manner of Death	28a. Date	of Injury	28b.	Time of Inj	ury 28c. Injury	at Work?	2	8d. Describe	how injury o	occurred		
On and in the further the furt	[교	1 Natural 5 Pend	dia a	h, Day,Yeár) 7/21/08	End	2:33	1 Ye	s 2 X	No S	subjec	t drow	med		
isic Atte er dez recto by tl	<u>ca</u>		28a Pla				, factory, office but	ildina. eta	. 2	8f. Location	(Street and I	Number or	Rural Rou	ite Number, City
Divis Sepital or A hours after meral Dire y filled in b	Certification:	dete	d not be	found :			,	3,		or Town,	State)S1i Branch	go Cr	eek	nte Number, City North of
ospit hour uner	ပ္	20a Certifier						4 -1-						riD
Division of Vital Rec To the Hospital or Attending Physician: The J within 24 hours after death. To the Funeral Director: After this certificate!	ica	(Check only one) 2 Medical Exa	hysician: To the be miner:On the basis											e(s)
To t with To t	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (
	-	255. Signature and title or certific											nonui, Da	y, i dai j
		well de	ve	270			O.C.M	.⊏.			July 22	2, 2008		
o (1)		30. Name and address of person		,	,		22. 76							
N 0		Russell Alexander MD		Medical Exa			Penn Street, E	Baltimo.	re, MD	21201				
	tate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	atur	RI					OCME			
Regis	trar	1111 9 0 2008	FU all se	15 1	1									

State of Maryland / Department of Health and Mental Hygien ? \(\begin{align*} \begin{align*} \Omega \\ \Omega \end{align*} \] 25178

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28a-f ehow eny injury or other traumatic event, the Medical Examination in the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

To the Funerel Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar				Cer	tificate of	Death	1		Reg. N	0.				
	1. Decedent's Name (First,	, Middle, Las	t)						2. Date of D			3. Time of Death			
n	Elmer	I.		Marcer	on				Month July	26	ay Year 2008	9:40 A.M	l		
ii r	4a. Facility Name (If not ins	stitution, give	street and nu	m <i>ber)</i>		4b. City, Town, o	r Location	of Death		4	c. County of Death				
	1083 Lake S	hore D	rive			Oakland	l				Garrett				
	5. Social Security Number			7. Age (In yrs. Ia	ast birthday)	If Under 1 Year		24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Foreign	n		
	577-05-6125	11	XM 2□F	96	Yrs.	Months Days	Hours	Min.	(Month, D		911 Wash	ington, DC			
	Usual Residence of Deced	dent													
	10a. State 10b. 0	County		10c. City	, Town or Lo	cation						10d. Inside City Limits			
ğ	MD G	arrett	:	0a	kland							1 ☐ Yes 2X☐ No	F		
ě	10e. Street and Number					10f. Zip Code				10g. C	Citizen of What Cou	ntry?			
Funeral Directo	1083 Lake S	hore D	rive			21550)			Ur	United States				
Jer.	11. Marital Status			edent Ever in U.S	S. 13. V	Was Decedent of I	lispanic O	rigin? (Sp	ecify Yes or N	0-	14. Race - Ameri				
	1 Never Married 2	Married Married	Armed Fo	2 XNo		r res, specify cub 1 □ Yes 2 🛣 No			Hican, etc.)		Black, White,	etc.			
Completed by	3 ☐ Widowed 4 ☐ Di	ivorced	If Yes, Gir Year or D	ve ates:		1∐ Yes 2LALNO	Specify	' :			Specify: Wh	ite			
ed		ecedent's Ed	ucation de completed)		16a. Deced	ient's Usual Occu	ation	et of work	100	16b.	Kind of Business/Ir	ndustry			
pe	Elementary/Secondary (College (1-4or 5+)	life. I	kind of work done DO NOT use retire	d)	SI UI WUIK	"ig						
Ö	12	` ′			E	lectricia	ın			Fe	ederal Go	vernment			
3e	17. Father's Name (First, A	Middle, Last)					18. Moth	er's Nam	e (First, Middle	e, Maide	en Sumame)				
0	Alexius	M	farcero:	n			Ge:	rtrud	le	Bur	ch				
	19a. Informant's Name/Re	elationship (7	урв, Print)		19b. Mailin	ng Address (Stree	and Numb	er or Rur	al Route Numi	ber, City	or Town, State, Zi	o Code)			
	Joan Schell	ing, I	aughte	r	1083	3 Lake Sl	nore 1	Drive	e, Oakl	and	, MD 2155	0			
	20a. Method of Disposition		2.2		ace of Dispo	sition (Name of natory or other pla	ce)	7/3	Date / O Q	20c.	Location - City or T	own, State	Т		
	1 Burial 2 Crem			State	•	coln Ceme				Bre	entwood,	MD			
	21. Signature of Funeral S	Service Licen	see				0.000			_	Home, P.A				
	Ketheren	in A	WEITHER			ZI N.	econ	d St.	. Oakl	and	, MD 2155	Ö			
	23a. Part1. Enter the dise shock, or heart failur			caused the death	. Do not ent							Approximate Interval Between			
	Immediate Cause (Final	re. List only	one carse on (,	- 1	1 4				ido. T	Oncot and Dogth	,		
	Immediate Cause (Final disease or condition resulting in death) a. a. a. a. a. a. a. a. a. a. a. a. a. a														
with dysphagea and decreased															
ē	Sequentially list conditions D.														
듣	cause (Disease or injury that initiated events														
Examiner	resulting in death) Last	- 1	Due to	(or as a consequ	ience of):	0									
g		·	d												
Medicai			J												
-	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, ou	tcome of pregna	ncy						23d. Date of deliv	very			
Cla	in the past 12 month. 1 Yes 2 No			ointh 2 □ Fetal nant at time of de		<pre>]Ectopic pregnanc</pre> <pre>] Other (specify) _</pre>	у				Month	Day Year			
Physician	9 Unknown	1	9□ Unkn	own											
Y	Part II. Other significant of	conditions c	ontributing to d	eath but not resu	ulting in the u	nderlying cause gi	ven in Part	ŧ.	23e. Did	tobacc	o use contribute to	the cause of death?			
Completed by	polymusal	orach	breum	africa.	010	statich	1005	troot	17 10] Yes	2 No 3 Pro	bably 4 DUnknow	n		
ete	1 1	1			J		17	1	24a. Wa	s an	24h Were aut	opsy findings available	A		
Ĕ									aut	opsy formed	prior to c	ompletion of cause of			
	05 Man ann minus d'a						-		1 Yes	-	No 1 ☐ Yes	2□ No	-		
Be	25. Was case referred to examiner?		Hospital:			_ (0:	hor		th Check only		_		-		
9	1 ☐ Yes 2 ☐, No 27. Manper of Death		28a. Date		ER/Outpatier 28b. Time of	IL 3LI DOA	4 🗆 🗅	lursing Ho	28d. Describe		6 Other (Spec	ify)			
<u></u>	Natural 5	Pending investigation	(Mor	nth, Day Year)	Injury	Wid	nk?]Yes 2[7No	200. 0430110	3 11011 11	july obodinos				
Ca	Accident 3 Suicide 6	Could not be		of Injury - At ho	me farm str	reet, factory, office	,		28f Location	tion (Street and Number or Rural Route Number,					
E	4 🗌 Homicide	determined	build	ing, etc. (Specify	()	eet, factory, office			City or T			ar ricato tratigor,			
ŭ	29a. Certifier	Cartifying Ph	veicine: To th	n host of my know	wlodao doot	b account at the t	ma data e	and place	and due to the		(a) and manned on	at at a d			
Medical Certification;	(Check only 2 M	Aedical Exan	niner: On the b	e best of my kno basis of examinal aner stated.	tion and/or in	vestigation, in my	opinion, de	ath occur	red at the time	e cause e, date a	(s) and manner as and place, and due	to the cause(s)			
Me	29b. Signature and title of	f certifier	and mar			29c Licen	se number			29d. I	Date signed (Month	, Day, Year)			
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	- I work	ww	out !	un 1	رن	1)0	465	0		/	16-50	18			
D	30. Name and address of	person who	completed cau	se of death (Item	123a) (Type,	Print)	Hh.	.0	a . M.	40.	end, Md	21550			
J	31. Date filed Month, Day	Tack	cuser	Ma	1001	1 yeurs	u ru	gower	ry wa	NUM	na inc	11220			
е	31. Date filed Month, Day	y, Year)	0 2008	Registrar's Signa	ure A	19 10		,	/						

State Registrar

Kaiserud 13 32. Registrar's Signature 2 8 2008

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** Day 7:45 P M BENNIE EARL MCCALL ILELY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGE'S CLINTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV • 22 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1919 226-44-6447 88 NORTH CAROLINA **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Marylan 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evandous must be neutified at once. 1 Yes 2 □ No Funeral Director VA HAMPTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 RED ROBBIN TURN 23669 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK 2 Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOME MAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOHNSON** MOZELL **JAMES** STATON ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11443 WAESCHE DRIVE MITCHELLVILLE, MARYLAND 20721 EILEEN R.F. MCCALL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAMPTON MEMORIAL GARD. 7/24/08 HAMPTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner whole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2X No 1 ☐ Yes ours after death.

Jeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 03226 0 who completed cause of death (Item 23a) (Type, Print) dry NAMPOLIS 32. Registrar's Sig 2008ar) State Registrar

Benni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Waryla	•	rtificate of		-	Reg. No. 20(08 25180
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day 200	3. Time of Death
	/Medic		DENNIS	MERC	HANT		. City, Town, or Location of Death			
	Examin	er	4a. Facility Name (If not institution, give HOLY CROSS HOS			1	SPRING	4c. County of D		
	Funeral Director		229-70-1946	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da JAN 1	th y, Year) 1945 V	Birthplace (State or Foreign Country) IRGINIA
	and sw		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tor	MD PRINCE G	EORGE'S	HYATTS	SVILLE				1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
	ath wil		3513 MADISON ST		,	2078			USA	
5-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the Madical Evandrer is ust be notified at matter.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	pecify Yes or No- p Rican, etc.)	- 14. Race - 7 Black, V Specify:	American Indian, Vhite, etc. BLACK
21215-0	within 72 ho ene. than "natur in Vicion	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2 T H	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occup a kind of work done DO NOT use retire DNSTRUCTI	during most of worl d)	king	16b. Kind of Busine	ess/Industry
\subseteq	be od o	To Be Co	17. Father's Name (First, Middle, Last) UNKNOWN			JNDIRECTI			Maiden Surname)	VIII
ary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	Ě	19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, Sta	te, Zip Code)
	and 2 ealth a n 27 l		SYLVIA MERCHANT						LE,MARYLA	
ore			20a. Method of Disposition 1 ☐KBurial 2 ☐ Cremation 3 ☐			osition (Name of matory or other pla	ce)	Date	20c. Location - City	
			4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	<u> </u>		EN CEMETE 2. Name and Addre		/2008	REINS FUN	UTH CAROLINA
Ba	permit. Departi Importi any Inji		Phian Tre	deuch	7	474 LAND	OVER ROAD	LANDOV	ER,MARYLAI	ND 20785
1	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		-	ng, such as cardiac HEMORRHA		rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		TILLIORIUM.	.02		
		ner	sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		PHONIA				
	xecuter and II-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. SEPTIC Due to (or as a conse						
68760,	rtificate be executed ng physician and as the burial-transit	Medical E		d						
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o	tal death 3	☐ Ectopic pregnand	су		23d. Date o Month	f delivery Day Year
ď.	res that signed b be deta	by Pr	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
ğ	w require been sig should b	ted t	ACUTE RENAL FA	-				1 080	Yes 2 No 3	Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed	ACUTE LIVER FA					24a. Was autor	osy prio	e autopsy findings available r to completion of cause of
			ACUTE RESPIRAT 25. Was case referred to medical	ORY FAILURE				1 □ Yes	2 2 No 1 🗆	Yes 2 Auc
Vita	ysicia is cert directo	o Be	examiner? 1 Yes 2 No	Hospitat: 12 Inpatient 2	☐ ER/Outpatie	ent 3 🗆 DOA Oth	26. Place of Dea		<i>one)</i> dence 6 ⊟Other (Specify)
Division of	or Attending Physician: Ifter death. Director: After this certific in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o	of 28c. Inju Wor			how injury occurred	opesy)
Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Number own, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		ysician: To the best of my kininer: On the basis of examinand manner stated.						
	Vithi Vithi Com	Σ	29b. Signature and title of certifier		00 1	29c. Licen:			29d. Date signed (A	Month, Day, Year)
	الج		30 Name and address of person who	completed cause of death (Ite	am 23a) (Tyne	Print\	065485		U 7/17	12008
	<i>હે</i> ડં		BARBARA A. SUPANI	CH M.D. 1500	FOREST	GLEN ROA	D SILVER	SPRING,	MARYLAND	20910
	Sta		31. Date filed Month, 700 (Par)	32. Recal rar's S						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death (O) Month Year **Physician** 3-41 AM 2008 Cresa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Baltimare Tohns Horkins Baymer Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🔭 F 79 508-26-3154 Nebraska August Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 28a-f shov Crownsville Anne Arundel 1 ☐ Yes 2 No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 1001 Stoney Lane 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ò 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker s 1 and 2 should be filed with Health and Mental Hygie item 27 is marked other them 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James V. Cain Margaret C. Keenan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael K. Murray/son P.O.Box 334 Mt.Storm ,WV 26739 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition July 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, VA. Metropolitan Crem. 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signatule of Funeral Service Licensee 6512 NW Crain Hwy. Bowie MD 20715 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Onset and Death Immediate Cause (Final **Physician** tucke ha /Medical resulting in death) Due to (or as a consequence of): Examiner ett Pericardial Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Jer or Attending Physician: The law requires that the death certificate be executed vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Exami Adenocarchem Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months 5 Other (specify) ☐Yes 2 INo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Preumonia 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24a. Was an autopey portormed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 \square No ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 □ H\(0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2 To the f

State Registrar

31. Date filed (Month, Day, Year) 2 3 2008

29b. Signature and title of certifier

Bayview Medical Center 4940 Eastern Are ohns Hopking

MO/PAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

12ES-000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 885 11-5-08 ye Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William H. Marion 12:05 P M July 21,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's 16424 Abbey Drive Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□F 572-28-1733 82 June 21,1926 Washington, D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Ex⇒miner must be notified at 1 ☐ Yes 2 No Prince George's Bowie MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 16424 Abbey Drive Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M Auto Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mazie Oueen William M. Marion ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16424 Abbey Drive, Bowie, Maryland 20715 Phyllis A. Marion/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/25/2008 Brentwood, Maryland 4 Donation 5 Other (Specify) Fort Lincoln Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 try. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition UNU cancer **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မှ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 or Attending 1 Natural 22 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral I 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 8 29d. Date signed (Mpnth, Day, Year) 29b. Signature and title of certifier

To the Hospital

State Registrar

31. Date filed (Month, Day, Year) 2008

30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

Bestgate Rd. Annapolis, Md. 21401 900 selonick, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** ິ , 200 ື 11:32A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CHARLES CIVISTA PLATA MEDICAL CENTER Α. If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Months Days Hours Min 64 NDIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Marylan show ms 23a or 28a-f sho 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10/03 Han 10e. Street and Number 20 206 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Evaluation cane. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status SIAN 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ≧ Specify: LNDIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Weadons Engineer irst, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MATIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2. MATIN (SON) HAMMAD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1242 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner 100100SL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate 1 ☐ Yes 2 within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) -0053219 9 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POST OFFICE RD. WALDORF, MD. 20602 ANSARI M.D. 7-E State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene O O O

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	-	For State Registrar		-	rtificate c		F	Reg. No. Z U	08	2518		
Physici	an	Decedent's Name (First, Middle, Last)		C+11			2. Date of Dea Month July	Day	Year 2008	3. Time of Death 3:00 a M		
/Medic		4a. Facility Name (If not institution, give	Cleveland Mc	GIII	4h City Tow	n, or Location of Dea		4c. County		3.00 a		
Examir	ier	Anne Arundel Medica				Annapolis		,	ne Aru	mde1		
Funeral		5. Social Security Number 6. Sec		n yrs. last birthday)	If Under 1 Ye	ear If Under 24 Hr		h		place (State or Forei		
Director	s I	530-09-6816 Usual Residence of Decedent]M 2□F	90 Yrs.	Months Da	ys Hours Mir	August 2			rizona		
land ow It		10a. State 10b. County	10	c. Cify, Town or Lo	ocation		-			I0d. Inside City Lim		
Mary f sh	to	Maryland Anne Arun	de1			Gambrills	3			1 ☐ Yes 2 K I		
r 28a	Director	10e. Street and Number			10f. Zip Coo	le		10g. Citizen of	What Cou	ntry?		
3a o		2608 Chapel Lake C	ourt. #405			21054			U.S.A			
death ms 2	Funeral		12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Rac	14. Race - American Indian, Black, White, etc.			
72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 194		1 ☐ Yes 2 ☑		erto nicari, etc.)	Specif	y:	White		
hou sal E	ed	15. Decedent's Edu		16a. Dece	dent's Usual Oc	cupation	I	16b. Kind of B				
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within jiene.	E	Elementary/Secondary (0-12)	5+		Public A	ffairs Offic	er	U.S. Army				
be filed within 72 ho ital Hygiene. do other than "natu event, the Medical	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surnar	ne)			
should be nd Mental marked o matic eve	To B	Neil Atkinso	n McGill				Ozella Mae	Ege1ston				
S P E E		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Maili	ng Address (Str	reet and Number or I	Rural Route Numbe	er, City or Town	, State, Zij	code)		
and 2 salth a n 27 is	l e	Jennie L. McGill - Sp	ouse	2608	B Chapel	Lake Court,	#405, Gamb	rills, Ma	ry1ano	1 21054		
is 1 an of Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			Date	20c. Location				
		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Ft. Linco		1	/27/2008	Brentwoo	od, Ma	ryland		
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	ee	2	2. Name and A	dress of Facility 1di Funeral						
<u>~</u> □ = « •		23 Part1 En er the disease, or compl shock in heart failure. List only o	ications that caused the			Hampshire Av			, Mary	Approximate		
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Physician /Medical		disease or condition resulting in death)		2515								
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	20a Cartifiar 1X Cartifying Phy	reician: To the best of	my knowledge, dea	th occurred at t	ha time, data and pla	and due to the	onueo(e) and m	annor ac	etated		
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12		Manay R				1202000		70	117	1 (70%		
		30. Name and address of person who c				Jerdy Ri						
		Anne Arund	el Med	CCI (enter	17Wcb	01,5 M	10 21	101	·		
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ORIGINAL

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		_	For State Registrar	State of Marylai	Ceri	tificate of	Death		Reg. No.	2008	25185
	Physici		1. Decedent's Name (First, Middle, Last, Tommy Morrison					2. Date of D		2008 ^{ear}	3. Time of Death 7:00 A. M
	/Medic Examin	- 1	4a. Facility Name (If not institution, give Hillhaven Assisted Lvg	street and number) Nursing & Reha	b Ctr.	4b. City, Town, o Adelphi	r Location of Deat	h		County of Death	orge's
c	Funeral Director		120 03 0 102		last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth yard	13 Alas	place (State or Foreign ama
	e Maryland a-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		ity, Town or Loc elphi	ation					10d. Inside City Limits 1 □ Yes 2 No
	h with the	al Dire	10e. Street and Number 3210 Powder Mill R	oad		10f. Zip Code 20 7 83			_	zen of What Cou ted Stat	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ズ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	/as Decedent of H Yes, specify Cub ☐ Yes 2 XNo	Hispanic Origin? (S ean, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	lo-	o- 14. Race - American Indian, Black, White, etc. Specify: White	
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/lanc	uld be fi Mental H rrked ot rric ever	To Be	Hugh McLean Morris	on			Minnie		o, maidon		
Mary	nd 2 sho Ilth and 1 27 is ma r trauma		19a. Informant's Name/Relationship (7) Maureen M. Hoffman	rpe. Print) n =niece	19b. Mailin	g Address <i>(Street</i> 3th Road	and Number or F ,#203 Ar	lural Route Num Lington	ber, City o Vir	r Town, State, Zi g ini a 2	2204
Baltimore, Maryland 21215-0036	Pages 1 ar		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify,	removal from State F	Place of Dispos cemetery, crem t. Linco	sition (Name of natory or other pla oln Ceme	tery 7/2	Date 2/2008		ntwood,	own, State Maryland
Balti	permit. Departm Importa any Inju	1	21. Signature of Funeral ervice Livens		Br	Name and Vodro	esBorgWard	dt Funer	ral Holling	ome, PA	yland 20 7 05
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or comp shock, wheart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	lications that caused the de ne cause on each line. a. Respirator Due to (or as a conset) Dementia Due to (or as a conset)	ath. Do not enter Y Failus equence of):	er the mode of dy					Approximate Interval Between Onset and Death
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
P.O. Box 6	requires that the death certifi een signed by the attending hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnand Other <i>(specify)</i>	су		-	23d. Date of deliv Month	very Day Year
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	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kainer: On the basis of exam and manner stated.	nowledge, deat ination and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to t curred at the tin	he cause(s ne, date an	and manner as d place, and due	stated. to the cause(s)
\	To the Position 24 within 24 To the I complete	Me	29b. Signature and title of certifier	, ,			nse number D45217		1	te signed (Month) $1_{ m y}$ 21, 2	
	15		30. Name and address of person who and Adebowale Ajayi, N			Print)		o Porle			
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	road, #UI	.ourreg	e rark,	пагу	Talia 201	<u>'+</u> ∪
DH	Regist	-	UUL 2 2 20	The factories	15. 190	ALL!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008

			1 - State Registrar	State of Marylar			f Health of Death		Re	eg. No.	008		
	Physici /Medic		Decedent's Name (First, Middle, Last) ELAINE JARMAN	MAUSER					2. Date of Death Month JULY	Day	2008	3. Time of Death 4:30P M	
	Examir		4a. Facility Name (If not institution, give st BUCKINGHAMS CF				n, or Location				County of Deat		
l.	Funeral Director		370-44-7002	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Your Months Da		24 Hrs. Min.	8. Date of Birth (Month, Day, APR 1	Ť°Š'1	7 9. Birt	hplace (State or Foreign	
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD FREDER		ty, Town or Lo ADAMS							10d. Inside City Limite 1 ☐ Yes 2 ☑ No	
	n with the	al Director	10e. Street and Number 3200 BAKER CIRC	CLE		10f. Zip Coo 2	1710		10	0g. Citiz	en of What Co		
5-0036	hours after death with the Maryland turel', or Iteme 23a or 28a-f ehow at Examiner rout be notified at	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent f Yes, specify (cify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: W		
0-61212	within 72 ane. then "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Ookind of work do DO NOT use re ETARY	ccupation one during mos atired)	st of workin	ng		d of Business/	3. Time of Death 4:30P M CCK Inplace (State or Foreign Intry) IA 10d. Inside City Limits 1 Yes 2 No untry? A Indian, Indi	
yland	D 9 2 0	To Be	17. Father's Name (First, Middle, Last) EDWARD JARMAN						(First, Middle, MIAYER	Maiden S	Su <i>m</i> ame)		
, Mar	alth a		19a. Informant's Name/Relationship (Typ	e, Print) SON	19b. Mailir 119	ng Address (St	reet and Numb TON DR	erorRura	I Route Number,	City or TOW	Town, State, 2 IN, PA	^{Zip Code)} 17340	
aitimore,	permit. Pages 1 a Depertment of Hee Important: If item eny Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State ST	Place of Dispo cemetery, cren I. MAR HURCH	CEMET	ERY	7/24			ation - City or	Town, State LLE, MD	
g	Depermit Deper Impor eny In		21. Signature of Funeral Savi License	ĺ	22 H P	Name and Ad ILLTON O. B	ddress of Facili FUNER OX 86	RAL F BAF	HOME RNESVIL	LE,	MD	20838	
68/60,	Cate be executed hysicien and physicien and physicien and the burial-transit in the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to mine distinct cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consec	Unsquence of):	suttice		Cardiac o	rrespiratory arre	951,		Interval Between	
C. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregn Other (specify				23	3d. Date of del Month		
cords, P	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions cont	ributing to death but not res	sulting in the ur	nderlying cause	given in Part I					the cause of death?	
e L	The lay ete has pege 2	Completed							24a. Was ar autops perform 1 Yes 2	y ned?	prior to death?	itopsy findings available completion of cause of 2 No	
r vital	S S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	ER/Outpatien	t 3 DOA	Othor		Check only one		☐Other (Spec	cify)	
IVISION OF	To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	27. Manner of Death 1 KNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	Injury at Work? 1 Tes 2	No 2	28d. Describe ho	w injury	occurred		
2	ours after ours after ours after ours after oursel blrechilled in by	al Certif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special cian: To the best of my kno	fy) 				City or Town	, State)			
	the Hos in 24 h the Fur pletely	edical	one) ZLJ Medical Examine	and manner stated.	ation and/or inv	estigation, in r	ny opinion, dea	ith occurre	ed at the time, da	ate and p	place, and due	to the cause(s)	
	To To To I	Σ	29b. Signature and title of certifier	m			cense number	771			signed (Mont		
j	Q		30. Name and address of person who con Yvette Wavven M	onleted cause of death (Iter	n 23a) (Type,	Print)	0058. Ct.						
18	Sta Registr		31. Date filed (Month, Day, Year)	32. Register's Signa 2008	ature	South	,	. 4	St. M. D. 18 2 St.	-			

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 19, 2008 **Physician** Doris M. Mathews 7:00 a м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Taneytown 4729 Babylon Road 8. Date of Birth Feb 17, 1925 9. Birthplace (State or Foreign Country)
So. Dakota 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Months 1 □ M 2 🕱 F 83 376-24-2391 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Taneytown Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 220 and any injury or other traumation. 21787 4729 Babylon Road USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ģ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Market Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Schwagerl William Benolkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4729 Babylon Road, Taneytown, MD 21787 Shelda L. Torres, daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Auer Memorial Home 1 ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/24/2008 Harrisburg, PA 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service 136 E. Baltimore Št, Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the de.wh. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): Box 68760. signed by the attending physician is detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 icate has been siç ; page 2 should b 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate I or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 JL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER 31. Date filed (Month, Day, 32. Registrar's Signature Year) State JUL 2 Registrar 2008

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

l	snock, or neart failure. List only o	ne cause on each line.			Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma Due to (or as a consequence of):	of the ovary		one week
niner	Sequentially list conditions, if any, leading to immediate cause Enter Underhing Cause (Disease or injury	b			
ical Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date	of delivery th Day Year
	Part II. Other significant conditions co.	ntributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contri	bute to the cause of death?
ğ			yg		3 ☐ Probably 4 ☐ Unknown
ted	Necrotizing f	asciitis		I Tes ZMINO	S Probably 4 Utilkriowii
Completed by				performed? de	fere autopsy findings available for to completion of cause of eath? ☐ Yes 2☐ No
Be	25. Was case referred to medical examiner?		26. Place of Deat	th (Check only one)	
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Nothe	r (Specify) Hospice
	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurre	d
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
edical (29a. Certifier 1 ⊠ Certifying Phy. (Check only one) 2 ☐ Medical Exami	siclan: To the best of my knowledge, death iner: On the basis of examination and/or inve	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s) and mar rred at the time, date and place, a	ner as stated. nd due to the cause(s)
M	29b. Signature and title of certifier	Jankon w	29c. License number D17040	29d. Date signed July 21,	(Month, Day, Year) 2008

State Registrar

within 24 the 2 NJL

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+3

215 Washington Heights Medical Center

Westminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard G. Lanham,

31. Date filed (Month, Day, Year)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Car1 McIntyre JULY 18, 2008 2026 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Cumberland **Allegany** 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Days Hours 219-14-5190 84 01/15/1924 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Frederick Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 M Yes 2 No 1943— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Food Market 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard James McIntyre Golda Juanita Lavender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille C. McIntyre / Wife 1110 Frederick Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Sunset Memorial Park 07/22/2008 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 404 Decatur Street, Cumberland, MD Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA HOURS Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jule to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Yes 5 Other (specify) 9□Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION. 1 Yes 2 No 3 Probably 4 Unknown ABETES MELLITUS. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy VITAMIN B12 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 | Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Division or Vital Records, P.O. Box 68760, certificate has birector, page 2 s ours after death.

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filled in by the fu

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

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Certification:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

10+ : DB w MM

Medical

State Registrar

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D62177

29c. License number

21502

29d. Date signed (Month, Day, Year)

2008

31. Date filed (Month, Day, Year)

JUL 2 1 2008

State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 2008 11:34 P Wilbur Α. July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Homewood at Williamsport Williamsport If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F 213-16-0086 85 Director December 09,1922 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Madical Evandour must be notified at 1 ☐ Yes 2 X No Director MD Washington Hancock 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code death with 14144 Heavenly Acres Ridge Road 21750 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If them 27 is marked other than ".... any injury or other traums". 12. Was Decedent Ever in U.S. Armed Forces? 1 by es 2 □ No If Yes, Give Year or Dates 943–1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🙀 No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Self Employed Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Landers ပ Jacob Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Funk/Daughter 14144 Heavenly Acres Ridge Rd Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial 07/30/2008 Hagerstown, MD 4 Donation 5 Dother (Specify) 21. Signature of uneral Service 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerebrovascular accident 6 hours /Medical Due to (or as a consequence of): Examiner atterosclerosis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown diabetes 1 Yes mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hypertension autopsy atrial fibrillation 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Maturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cymphia Kuttra-Sands 20 July 28, 2008 D47451 Cynthia Kuther-Sands MD Homewood Nursing Home, 16505 Virginia Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamsport, Maryland 21795 31. Date filed (Month, Day, Year) State AUG -Registrar

1 - For State Registrar

P	hysician
	/Medical
E	xaminer

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be confined at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, cate has bage 2 s certificate this

within 24 hours after death

To the Funeral Director:
completely filled in by the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2008 July 30, Charlotte June Mayne 4:25 PM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6820 Buckingham Lane Frederick Buckeystown 8. Date of Birth (Month, Day, Yea Sept. 23, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Year) Min. 1 □ M 2√2 F Months Days Hours 212-52-5716 54 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Frederick Buckeystown Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21717 (P.0. Box 1)6820 Buckingham Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 10 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black. White, etc. 1 Never Married Married 1 ☐ Yes 2XXVo Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor/United Methodist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Virginia Shaw Charles Kirby Ramsburg, Sr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6820 Buckingham Lane, Buckeystown, MD 21717 Mehrl F. Mayne, husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Nurial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug. 4, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) .22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Lice MO0255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑ No 24a Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) ttle of certifier 29c. License number July 31, 2008 30. Name address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Drive, Frederick, MD 21702 65 C Shah 31. Date filed (Month, Day, 32. Registrar's Signature Year! State Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** $P^{\ M}$ 2008 Elaine Dawson Maners Ju1v 25 1418 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 E1kton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 68 JAN 23, 1940 217-36-2865 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director Maryland Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or "natural", or Items 23a 306 Skipjack Court 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Health Care 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ۵ James L. Dawson, Sr. Evelyn M. Bedwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Michael P. Maners/Son 17 Reed Hartnett Street, Elkton, MD 21921 Important: If Item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor 20a, Method of Disposition v 30. 20c. Location - City or Town, State Ju1y Pages 1 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, MD Memorial Park 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on e ich line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anoma **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient P 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature e and address of person who completed cause of death (Item 23 a 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

q

2

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F ertificate of			ene 20	08 25193
	Division		1. Decedent's Name (First, Midd	dle, Last)				2. Date of Death Month	1	3. Time of Death
4	Physici /Medi		Mary Ida Newo	comer				07		08 0715 A M
	Examir	ner	4a. Facility Name (If not institution	on, give street and numb	per)	4b. City, Town, o	or Location of Death	ı	4c. County of	Death
	Funeral		WMHS-BRADDOC 5. Social Security Number		Age (In yrs. last birthday	CUMBERI If Under 1 Year		8. Date of Birth	ALLEGA	NY 9. Birthplace (State or Foreign
	Funeral Director		160-30-9058	1 □ M 2 X F	70 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country) Pennsylvania
	pu		Usual Residence of Decedent							
	shov	ō	10a. State 10b. Count		10c. City, Town or L					10d. Inside City Limits 1 ₩ Yes 2 □ No
	28a-f	rect	MD Garre 10e. Street and Number	ett	Grantsvil	10f. Zip Code		10	a. Citizen of Wh	
	death with the Maryland ms 23a or 28a-f show rmust be rollled at	Funeral Director	161 Killdeer I	ane		21536		11	ISA	
	death	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race	- American Indian,
36	or ite	by Fu	1 Never Married 2 X Ma	rried 1 ☐ Yes 2 If Yes, Give	∑ No	1 ☐ Yes 2 X No		Thour, etc.)	Specify:	White, etc.
21215-0036	hours tural"	q pa	3 ☐ Widowed 4 ☐ Divorce	d Year or Date		edent's Usual Occup	nation	1	6b. Kind of Busi	White
15	in 72 n "na	Completed	(Specify only high	est grade completed)	(Give	e kind of work done DO NOT use retire	during most of work		ob. Killa of basi	ness/muusi y
212	d with giene er tha	E C	Elementary/Secondary (0-12)	College (1-4		inistrato	r	H	ealth Ca	are Facility
nd	tal Hy d oth	Be	17. Father's Name (First, Middle	, Last)				ne (First, Middle, M	laiden Surname)	
yla	d Men narke	은	Harry Adam				June Mcl			
Maryland	d 2 st Ith an 27 is r traur		19a. Informant's Name/Relation Roy E. Newcome			ing Address <i>(Street</i> K illdeer			-	1536
ē,	s 1 an of Hea item (20a. Method of Disposition	E/ Hasbaria		osition (Name of ematory or other place			<u> </u>	ity or Town, State
altimore,	Page nent c ant: If ary or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Glade Ce			29, 2008	Accide	nt, MD
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Experiment must be required at once.		21. Signature of Funeral Service	Libensoe		2. Name and Addre				
8	205 # 9		of you	1 term		.O. Box 2				
30			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	st only one cause on each	h line.	iter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sep				Fewacys		
	Examiner			C- d	as a consequence of):					Few days.
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	a a consequence of):					
	ecuter Ind transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
8760,	cate be executed physician and the burial-transit	E E	resulting in death) Last	Due to (or	as a consequence of):					
687	ficate physi s the b	dical		d						
Box (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		me of pregnancy				23d. Date	of delivery
Ö.	death le atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregna	nt at time of death 5	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су 		Mont	h Day Year
P.O.	at the 1 by th stache	hys	9 ☐ Unknown	9 ☐ Unknov						
S,	ires that the de signed by the a l be detached i		Part II. Other significant condit Meta Stati			underlying cause giv	en in Part I.			bute to the cause of death?
Sorc	w requir been s should	eted	Mange	101200	Concer			1 Tes	-	
Records,	siclan: The law s certificate has b irector, page 2 sl	Completed by						24a. Was an autopsy perform	/ pri	ere autopsy findings available ior to completion of cause of ath?
Vital	ysiclan: The I is certificate ha director, page		25. Was case referred to medic	al			26 Place of Dea		No 1L	Yes 2 2 No
Ϋ́	Physicle this cer al direct	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 ER/Outpatie	ent 3 DOA Oth	or:	ome 5 Resider		(Specify)
0	ng Ph fter th ineral	E	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of (Month,	Injury 28b. Time (of 28c. Inju		28d. Describe how		· · · · · · · · · · · · · · · · · · ·
sio	tendi leath. Ior: A the fu	cati	2 Accident invest	tigation		M 1 □	lYes 2□No			
Division of	l or Attendi after death. Director: /	Certification: To		mined 28e. Place of building	Injury - At home, farm, st , etc. <i>(Specify)</i>	reet, factory, office		City or Town,	eet and Number , State)	r or Rural Route Number,
ш	spital lours a neral filled		29a. Certifier 1/5 ertify	ing Physician: To the b	est of my knowledge, dea	th occurred at the ti	ime, date and place	, and due to the ca	ause(s) and man	ner as stated.
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medica one)	I Examiner: On the bas and manne	is of examination and/or i r stated.	nvestigation, in my	opinion, death occu	rred at the time, da	ite and place, ar	nd due to the cause(s)
_	To the Comp	ž	29b. Signature and title of certifi			29c. Licens		29	d. Date signed	(Month, Day, Year)
			▶ Hmast	iail mo		124	6346		1/27/	US
		12	30. Name and address of person	1 1 1	11 1 0		()	1	M	0
	Sta	te	31. Date filed (Month, Day, Year	10 KI 625	Kent (Uv	enue,	Lumbe	erland	, Mari	land 21502
	Registr		JUL 3	0 2008	mas B. A	books				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 19, Da 2008 Year 6:15 Natallee N. Nickulas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth DeC 9. Birthplace (State or Foreign Country) Canada 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 592-34-7840 33 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Crofton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 USA 2092 Lake Grove Lane Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify þ 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, the Me College (1-4or 5+) Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Allen Nickulas, Jr. Helen Winfred Irwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2092 Lake Grove Lane Steven Robey / Life Companion Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 7/21/2008 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Phonies 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stomach Immediate Cause (Final 4 months **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No

certificate has tirector, page 2 s funeral director, Be ^o Certification: After

within 24 hours after death.

To the Funeral Director: /

or Attending Physician: To the

State Registrar

Medical

Wern

29b. Signature and title of certifier

25. Was case referred to medical

1 Tyes

27. Manner of Death

1 Watural 21 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

2 No

5 Pending investigation

6 Could not be determined

900 Bestagt Road # 300, Amepolis, MD 21401 MO 32. Registrar's Signatur

1 🔲 Inpatient

(Month, Day Year)

28a. Date of Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MIN

Injury

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Huse

08-05521	
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Edilma Paulina Sacalxot

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25195

	1- For State	Certific	ate of Death	Reg. I	No
Physician	1. Decedent's Name (First, Middle,Last)			Date of Death Month Da	3. Time of Death
edical Examine		Sacalxot Ordon		July 18, 2008	B 1643 1115
1	4a. Facility Name (if not institution, give s Reisterstown Road and Slad		4b. City, Town, or Location of Pikesville		4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex None 1 M	7. Age (In yrs. last bir	thday) If Under 1 Year If Under Months Days Hours		9. Birthplace (State or Foreign Country) Guatemala
w any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Md Baltimor 10e Street and Number	e Owing	10f. Zip Code		Citizen of What Country?
vith the N s 23a or e notified		Was Decedent Ever in U.S.	21117 13. Was Decedent of Hispanic Orig	gin? (Specify Yes or No-	uatemala 14. Race - American Indian, Black,
ter death with ", or items 23 er must be no		Armed Forces? 1 Yes 2 X No Yes, Give Year	If Yes, specify Cuban, Mexican 1 X Yes 2 No specify:		white, etc. Specify: Hispanic
72 hours afte n "natural" al Examine	Elementary/Secondary (0-12)	6b. Kind of Business/Industry			
215-0036 be filed within 72 ntal Hygiene. rked other than 'ent, the Medical	9th		House Cleaner	's Name (First, Middle, Mai	Home
21215. Uld be filed Mental Hy marked or		alxot		na Ordonez	
MD 21215-003 at 2 should be filed within the and Mental Hygiene. The annualic event, the Med annualic event, the Med		1	9b. Mailing Address (Street and Nur 45 Tahoe Cir Owir		
nore, ages l ar nt of Hea nt. If ite	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State 20b. Place crema	of Disposition (Name of cemetery, atory or other place) eral Cemetery	Date 2 07/27/08	20c. Location - City or Town, State Guatemala
Baltin permit. P. Departme Importan injury or	21 St. nature of Funeral Service Ligens	eral Services 1501 Md. 20783			
Physician 'Medical	23a. Part I. Enter the disease, or complic failure. List only one cause on each	t, shock, or heart Approximate Interval Between Onset and Death			
xaminer		ultiple Injuries ue to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):			
.=	events resulting in death) Last	ue to (or as a consequence of):			
'60, zate be executed physician and he burial - trans	UNPENDED	AMENDED			
68760, certificate bunding physic ise as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnance 1 Live birth Pregnant at time of death		ic pregnancy	23d. Date of delivery Month Day Year
Box 687 he death certific	<u>≥</u> — — — —	9 Unknown		Table 11 to 1	the state of death?
P.O. es that the signed by be detac	<u> </u>	contributing to death but not result	ing in the underlying cause given in F	u.,	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ords, aw requir las been s 2 should 1				24a. Was an autopsy perform	prior to completion of cause of
tal Recor				1 ✓ Yes 2	
tal	25. Was case referred to medical	spital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other	Nursing Home 5 R	tesidence 6 🗸 Other: Scene
1 of Jing Ph After t funeral	27 Manner of Death	28a. Date of Injury FOUND: FOUND: FO	DUND: 28c. Injury at Wo	rk? 28d. Describe ho	ow injury occurred estrian struck by vehicle
ivisior or Attence after death Director:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,	34 hrs farm, street, factory, office building,	etc. 28f. Location (Str	reet and Number or Rural Route Number, City ate) load and Slade Avenue, Pikesville, MD
bou hou y fil		n: To the best of my knowledge, on the basis of examination and/o	Highway death occurred at the time, date and p ir investigation, in my opinion, death o	lace, and due to the cause	(s) and manner as stated.
To the within To the comple	(Check only 1 Certifying Physicia one) 2 Medical Examiner: 29b. Signature and title of certifier	and manner stated.	29c. License numbe	er	29d. Date signed (Month, Day, Year)
Je Je	Theoder 711	Kind The	O.C.M.E.	OCME	July 19, 2008
(3)	30. Name and address of person who con Theodore M. King, Jr., MD.	Assistant Medical Exa		altimore, MD 21201	
Sta Registi		32. Registrar's Signature	S)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25196

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	Re	For State		Cert	ificate of	Deati	7		2 Da	Reg. Nate of Death	√ 0.	3. Time of Death
Physician/ Marcal Examine		Decedent's Name (First, Middle,Las	1010)nda	ra			Mo	onth Da ly 19, 2008	y Year	1643 hrs
l la Exami		Facility Name (if not institution, given	ve street and number)				own, or Lo	ocation of Dea		.,,	4c. County of Death	
		1955 Coyotes Circle Road	d			Chesa	apeake	100			Cecil	
Funeral	5.	Social Security Number 6. S	ex 7. Age	(In yrs. las	st birthday)	If Unde	r 1 Year Days	If Under 24H Hours M	irs. 8. [Date of Birth (M	/M/DD/YYYY) 9. Birt Foreig	hplace (State or
Director	1	221-06-8880 1	M 2 F	2	S Yrs		Days	Tiodis IV		09-27	- 1984 co	untry) Kenya
· A		sual Residence of Decedent 2a. State 10b. County	14	Oc City 7	Town or Locati	on						10d. Inside City Limits
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r death with or items 23	1	Never Married 2 Marrie	Armed Forces?	X _{No}	If Y	es, specif	y Cuban, I	Mexican, Puer	rto Ricar	n, etc.)	White, etc.	Black
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hours natura		15. Decedent's Education (Specify of			16a. Deceder during m			on (Give kind o DO NOT use r		done 16	Sb. Kind of Business/ Ituman	Industry
36 in 72 han " lical J		Elementary/Secondary (0-12)	College (1-4 or 5-	+)	Trick	10		Ai	1			services_
21215-0036 Uddhe filed within 72 hour Mental Hygene. marked other than "matu e event, the Medical Exan	17	7. Father's Name (First, Middle, Las	t)		Instr	ucn		8.Mother's Na	me (Firs	st, Middle, Maid		JET VICES
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re, M s 1 and 2 of Health of Health If item 2	11	Da. Method of Disposition Machine Burial 2 Cremation 3	Removal from Star	e c	Place of Dispos rematory or ot	her place)			l l	OC. Edication - City of	Town, State
Page Page ment cant:	4	Donation 5 Other Specific		<u> Ona</u>	tora Fa	amily	Ceme	try 08	5-01	-2008	Kerok	z. Kenya
Baltimore, MD 21215-0036 permit Pages I and 2 should be filled within 72 hours after death with the permit Pages I and 2 should be filled within 72 hours after death with programs. If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be To Re Completed by Funera	2	1. Signature of Funeral Service Lice	ensee //					of Famility S			y Family wark. Di	
	2	3a. Part I. Enter the disease, or con	nplications that caused t	he death.	Do not enter t	he mode	of dying, s	uch as cardia	c or res	piratory arrest,		Approximate Interval
Physician Medical		failure. List only one cause on	each line. a. Multiple Injuries									Between Onset and Death
xaminerے		nmediate Cause (Final disease a condition resulting in death)	Due to (or as a conse	quence of):							
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0, e be execut ysician and burial - tra		UNPENDED	AMENDED								23d. Date of delive	
Box 6876(he death certificate the attending phy, the attending phy, hed for use as the b	23	F FEMALE: 8b. Was decedent pregnant in the	23c. If yes, outcom	ie of pregr		etal death	3	Ectopic pre	gnancy		Month Month	Day Year
ox 6876 ath certificate attending phy or use as the		past 12 months? Yes 2 No 9 Unknow	4 Pregnant at	time of de		ther (Spe	ecify)					
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ital sician s certi	ă	5. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatien	t 3	_	Othor	rsing Ho		esidence 6 🗸 Oth	er: Scene
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ivision or Attence after death Director:	<u> </u>	2 ✓ Accident Investign 3 Suicide 6 Could n	28e Place of In	jury - At ho	ome, farm, stre	et, factor	y, office bu	uilding, etc.				tural Route Number, City
Div Hospital of 24 hours at Funeral L	Certification:	4 Homicide determin	T-F77 IVIA								te) Circle Road, Chesa	
		9a. Certifier 1 Certifying Physone) 2 Medical Examir	ician: To the best of mer:On the basis of exam	y knowled	ge, death occu	urred at th	e time, da	te and place,	and due	e to the cause(s) and manner as stand place, and due to	ated. the cause(s)
To the within 2 To the complet	ᇙᆫ		and manner stated.	IIII alion a			c. License		00 01 111		29d. Date signed (M	
	2	9b. Signature and title of certifier	W no			25	O.C.N				July 20, 2008	
	L	Morgante Un	e still	ooth (n-c-	220)		5.0.1				,,	
	3	 Name and address of person who Margarita Korell MD. 	o completed cause of d Assistant Medical			enn St	reet, Ba	altimore, N	/ID 212	201		
(p	te 3	31. Date filed (Month Day, Year)										
Registra	ar	JOL X 3	2008 Flee	we.	Jre K	DONEL	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 800 P M 2008 ickavance /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Peninsula Salisbur Wicomic ROGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last **Funeral** Months Days Hours 1 M 2 □ F 9-1954 236-88-66 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director HCCOmac K 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3235 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Bes 2 No If Yes, Give Year or Dates: 1975-1981 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: Whitz 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Eastern Correctional suaro 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pickavance Mobinson Dennis 2 Joseph Telen can 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau Atlantic Pickavance Ad Gicta 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/24/08 Exmore, VA 4 ☐ Donation 5 ☐ Other (Specify) Creinstony Occohannock ChincoteagueLVA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Church St. timeral Home, Inc. 6327 Salyer Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se puentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Ye ar Day 5 Other (specify) been signed by the a should be detached to ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 □Yes 2 □No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month: Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbary M.D arroll Immy 1a 101

DHMH 17 Rev 1/2001

State Registrar

		1 - For State Registrar Ameno#5. Peri				artment o			lental Hygi	ene g. No. 2 (1 በ ይ	25198
		Registrar ATEL D#5. PEL Decedent's Name (First, Middle,		JOCI	001	Tincate (Dealii	<u>'</u>	2. Date of Death		100	3. Time of Death
Physic		Elizabeth T. P	,						July 14	Day 2008	Year	10:10 A M
/Med Exami		4a. Facility Name (If not institution,		ımber)		4b. City, Tow	n, or Location	of Death	<u> </u>	_	ty of Death	10.10
LAGIII		3108 Rosemary	Lane			Hyat	tsville	9		Pri	nce Ge	eorge's
Funera		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Y		r 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
Director		295-28- 3359	1 □ M 2 🖾 F	80	Yrs.		.,.		Sept 10,	1927	Jack	sonville, FI
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Maryi f sho	Ď	Maryland Prince	George'	S	Hyatts	sville			1 ∑]Yes 2[
r 28a-	Directo	10e. Street and Number	000181			10f. Zip Cod	de		10	g. Citizen of	What Cou	ntry?
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ems army	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					ace - Americ	
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LILL A LA I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent*	Year or I	Dates:	16a Dece	dent's Usual O	rcunation	_	16b. Kind of Business/Industry			dustry
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LICIDOUS af ed within 72 hours af gjene. er than "natural", or the Medical Exami,	E O	Elementary/Secondary (0-12)	4	(1-4or 5+)	Medi	ical St	atistic	cian		Go	overni	nent
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Malylallo d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	일	Frederick D. T	immons,	Sr.			Rho	oda L	ittle			
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		Maria Porter -	Daughter	l anh I		Rosem			yattsvil			
Dallinole; bermit. Pages 1 ar Department of Hea mportant: If Item; any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	cemetery, cirei	matorý or othei	place)			20c. Location	-	
it. Partmer rtant:		4 □ Donation 5 □ Other (Sp. 21. Signature of Fusial Service L		Mτ		et Ceme 2. Name and A		7/21		ashing		
Dalfind Dermit. Page Department of Important: If any Injury or once.		21. Signature of Puta and Service to	A		-							more Ave. e, MD 20781
- 70		23a. Part1. Enter the disease, or	complications that	caused the deat							3 V I I I C	Approximate Interval Between
Physician		shock, or heart failure. List of Immediate Cause (Final		each line. ration l	Pneumor	nia						Onset and Death
/Medical		disease or condition resulting in death)	a	(or as a consec		114					-	
Examiner		Comment the tink and distance	0rop	haryngea	al Dysp	hagia						
₽ #	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consid		1						
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equire equire en si	ed	Pulmonary embol	ism						1 ☐ Ye	s 2 No	3 ☐ Pro	bably 4∑Unknown
he law requires to has been signed age 2 should be or	Completed	Deep vein throm	bosis						24a. Was ar	1 24k	prior to co	opsy findings available
	S	Hepatitis - C -	infecti	on					perforn	ned? XX No	death? 1 ∐ Yes	2 □ No
VILCII sician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital: 4					e of Death	h (Check only one	e)		
Phys rthis gral dir	P	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2	ER/Outpatier 28b. Time o				me 5 Reside			fy)
dling P. After I	ion	1 ☑ Natural 5 ☐ Pending		e of Injury onth, Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐		200. Describe no	w injury occi	anea	
lor Attending after death. Director: Afte din by the fune	fica	3 Suicide 6 Could n	ot be 28e. Plac	e of injury - At h	ome, farm, str						nber or Rur	al Route Number,
al or Attendlas after death.	Certification:	4 Homicide	buil	ding, etc. (<i>Speci</i>	Ty)				City or Town	, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			Physician: To the									
the H iin 24 the F	Medical	one)		nner stated.								
_	2	29b. Signature and title of certifier	no)			cense number 0005737.		25	9d. Date sign	ned (Month,	Way, Year)
€		Vygor ()	ull	- IN	1/					_/(_	1	100
3		30. Name and address of person vizzat Chalabi,	•	use of death (Iter Hanove:	, , , , .		Greenh	elt	MD 207	74		
9	tate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	, "100,	OLCCIII		207	• •		
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DHMH 17 Rev 1/2001

ORIGINAL

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			Tor State of Maryland	/ Depa	artment of H Stificate of L	lealth and M D <i>eath</i>		ene 2 (08	25200
			Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
	Physicia		Robert Roy Parker				July :	16 ^{Day} 20	008 ear	8:45 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Count	ty of Death	
			Carroll Hospice Dove House		Westr	minster		Ca	rroll	-
ı	Funeral Director		5. Social Security Number 217−28−6875 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last 1 ☑ M 2 ☐ F	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Aug 24	Year) 1934	9. Birthp Cour	place (State or Foreign htry) MD
	pur \star		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	/aryla	ō		Vestmi						1 □Yes 2 🔂 No
	the N	Director	10e, Street and Number		10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	100	g. Citizen of	What Cour	ntry?
	3a or	<u>=</u>	377 Sunshine Way		21:	157		US	SA.	
	death ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-		ce - Americ	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show whit, the Medical Examination until be notified at	by	Armed Forces? 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 Married If Yes, Give Year or Dates:		l ∐Yes 2 ∑ No	Specify:	nicari, etc.)	Speci	ack, White, e ify: Whi	
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation Juring most of worki	na 16	6b. Kind of E	3usiness/Inc	dustry
2	i within 72 ho jiene. r than "natur r e Medical	h du	Elementary/Secondary (0-12) College (1-4or 5+)			luring most of worki	i	\m\ T		turd orbital day
	e filed w al Hygiel other th vent, m		17. Father's Name (First, Middle, Last)	Chie	et Financ	ial Analy 18. Mother's Name				inistration
and	\$ 2 a e) Be	Robert Parker				et Shiple		1110)	
Maryland	should be and Menta s marked umatic ev	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street a	and Number or Rura			n. State. Zir.	Code)
<u>S</u>	and 2 s ealth ai n 27 is ner trau		Sandra Parker/wife	377	Sunshine	Way Wes	tminster	, MD	21157	7
altimore,	of H		18 Buriai 2 Li Cremation 3 Li Removal from State		sition (Name of natory or other place Church Cet		/2000	oc. Location Westmi	•	
Ħ	permit. Page Department Important: If any Injury or once.		4 Donation 5 Other (Specify) 21. Signature of Protectal Service Licens e			ss of Facility neral Hom				
m	Der Sung		X. (It muth)			gton Road				21157
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O, Box	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	death 3	Ectopic pregnancy Other (specify)	<i>y</i>			Month	Day Year
rds, P.	requires that the neen signed by th nould be detache	ğ	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause give	en in Part I.				he cause of death?
Records,	sician: The law red certificate has bee irector, page 2 shou	Completed					24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available impletion of cause of
Vital	sician: 7 certifical rector, pa	Be C	25. Was case referred to medical			26. Place of Death	1	DYNo	1 □Yes	2000
	Physician: r this certific ral director, I	0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	nt 3 □ DOA Othe	DE'	me 5 🗆 Residen		ther (Speci	W Dont Govern
Division of	e te	ation: T	1	28b. Time of Injury	Work		28d. Describe how			
DIVIS	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		iber or Rura	al Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical	29a. Certifler (Check only one) 1- Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occuri	red at the time, dat	te and place	e, and due to	o the cause(s)
	MJ P	Z	29b. Signature and title of certifier Rivert X River N	1011	y 29c. License	00645	-G7 291	d. Date sign	ed (Month,	Day, Year)
	15		30. Name and address of person who completed cause of death (Item 1)	uth	Covers	Shootli	ESTMIL	De i	MD6	2157
	Sta Registr		31. Vate filed (Month, Day, Year) 32. Registrar's Signatu	re L. J.	park					

		1 – For State Registrar	State o	f Marylar		artmen rtificate				lental Hy	/giene	200	38	252	201
Physic /Med	ical		UINN			41. 01.	F	Landing	of Dooth	2. Date of Do Month July	19°		Year 08	3. Time of I	Death A M
Exami		4a. Facility Name (If not institution, Casey House 5. Social Security Number	give street and nu	7. Age (In yrs.	last hirthday)		kvi	Location of 11e		8. Date of Bi	N	County o	omer	-	r Foreign
Funera Director		010-42-1587 Usual Residence of Decedent	1 □ M 2 □ XF	58	Yrs.	Months	Days	Hours	Min	June 2	3,195	50	9. Birthp Coun MA	try)	
he Marylan 28a-f show	ector	10a. State 10b. County MD Montg 10e. Street and Number	omery		ity, Town or Lo						10a Cit	izen of WI		0d. Inside Cit 1 ☐ Yes	
ath with I	Funeral Director	12721 War Admir				208	378–3				Unit	ted S	tate	:S	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Eventhal mist be rotilised at any nice.	þ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	2 XNo ve		Was Deced If Yes, spec 1 □ Yes 2		ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-		, White, e	an Indian, etc. ite	
d within 72 h giene. er than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Dece (Give life. Mater:	dent's Usua kind of wor DO NOT us Lals F	k done d e retired	luring mos ')	Scie	ntist	Rese	ind of Buse earch elopm	and		
Tallylallallallallallallallallallallallal	To Be (17. Father's Name (First, Middle, L Edward Gorcens	k1					F1	oren.	ce Har	evich	n	-		
and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationshi George D. Quinn	p (Type. Print) (Husbat		1272	War	Adm	iral		al Route Num. Gaithe	rsbui	rg, M	ID 20	878-32	:79
Pages 1 ment of H ant: If Iter lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		State	Place of Dispo cemetery, crei tropol:	itan (Crem	•	July 200	8	Alex	cation - C	ia,		
permit. Departit Imports any Inj		21. Signature of Fungral Service L	(dely-		10) East	: De	er Pa	rk D	Vol Fu r. Gai	thers			20877	<u>'</u>
Physician /Medica		23a. Part1 Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on a. Lung	caused the dea each line. Cancer (or as a consec		ter the mode	e of dyin	g, such as	s cardiac	or respiratory	arrest,			Approximate Interval Bety Onset and E	ween
Examined and transit	Examiner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Coude (bleads or in any that initiated events resulting in death) Last	c	(or as a consec											
ificate be ex g physician as the burial	dical	resulting in death) Last	d.	(or as a consec	quence of):										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	1 ☐ Live	tcome of pregr birth 2 Tet nant at time of nown	aldeath 3[☐ Ectopic pi ☐ Other <i>(sp</i>		/				23d. Date Mor		,	/ear
w requires that been signed to should be deta	b	Part II. Other significant condition	ns contributing to c	leath but not re	sulting in the u	nderlying ca	ause give	en in Part I	l. 					ne cause of d pably 4 🔀 U	
ar neco :: The law re icate has be ; page 2 sho	Completed									24a. Wa aut per 1 ∐Yes	opsy formed?	p		psy findings ampletion of ca	
V IL.	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only					
Phy C	5	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time o		<u></u>	4 🗆 141		ome 5 ☐ Res 28d. Describe				y) Hosp	1ce
ttending death. tor: After the fune	ertification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation	nth, Day, Year)	Injury	M		ć? Yes 2□	No						
oltal or A urs after ral Direc	O	4 ☐ Homicide determin	build	e of Injury - At h	ify)						òwn, State	e)			per,
he Hosp in 24 ho he Fune pletely f	Medical	29a. Certifier (Check only one) 1. Certifying 2 Medical E	Physician: To the xaminer: On the and mai	e best of my kn casis of examinated.	nowledge, dea nation and/or in	th occurred evestigation	at the tir , in my o	ne, date a pinion, dea	nd place, ath occur	and due to the	ne cause(s e, date an	s) and ma d place, a	nner as s	stated. the cause(s)
10 To with com	Z	29b. Signature and title of certifier	holle	u	w	290		e number 64615	i			ite signed Ly 19		Day, Year) 108	
		30. Name and address of person v					rd D	r. Su	ite	100 Ro	ckvi.	11e,	MD 2	20850	
S Regis	tate	31. Date filed (Month, Day, Year)	2008	egistrar's Sign	nature	anti)									

		•	1 - For State Registrar	State o	f Maryland	d / Depa	artment of H rtificate of L	ealth a	nd Me		gien@ () (8 0	25202
	Dhysiai		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Vivian Jur	ie Rec	kart					July		800	9:02 P. ^M
	Examin		4a. Facility Name (If not institution	-			4b. City, Town, or	Location of	Death		4c. County	of Death	
			Garrett County				Oakland		A 11.5		Garr		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Count	
	Director		217-28-7656 Usual Residence of Decedent	- А	76	113.				June 10) 1932	Penns	sylvania
	land wo		10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits
	Mary -f •h	ğ	MD Garre	ett	Oa	akland							1 ☐ Yes 2 No
	28s	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Count	ry?
	3a ol		6160 Garrett H	lighway			21550				United	State	20
	me 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S	S. 13.	Was Decedent of Hi	spanic Origi	in? (Spec	cify Yes or No		e - America	ın Indian,
9	or ite		1 Never Married 2 Mari	Armed Fo	2X No		n Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Specify:	Pueno P	Rican, etc.)		ck, White, e	tc.
8	72 hours after death with the Maryland naturel; or tleme 23s or 28s-f ehow Jical Examination notified at	b	3 Widowed 4 Divorced	tf Yes, Gi Year or D	ates:		1 Tes 2 3+40	эрөспу.			Specif	Whit	e
21215-0036	a within 72 hours after death with the Marylan Jeen . r then "naturel", or iteme 23a or 28a-1 ehow the Marical Examinet maal be notified at	Completed	15. Deceden (Specify only higher	t's Education st grade completed)		(Give	dent's Usual Occupa	durina most	of workin	a	16b. Kind of B	usiness/Ind	ustry
2	within ene.	g.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,) -					
7			12	1		Nur	ses Aid	10 Method	da Nama	/Circh Middle	Hospita Maiden Surnan		Jursing Home
Maryland	A P T	Be	17. Father's Name (First, Middle, James Fole							_			
3	should by nd Menta marked	ဥ	James Fole	•		401- NA-111		Ros		Lee	Rile		0-4-1
Mai	treun				and		ng Address (Street a						Code)
	Hea the		Mr. James Reck 20a. Method of Disposition	.arc, nusp			Garrett			Oakland ate	20c. Location		vn. State
و	Pages nent of I nnt: if its ury or o		1 Burial 2 Cremation		State		sition (Name of natory or other place	I					
Baltimore,	artmen ortant:		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		BTG		Rose Cem				Friends		e, MD
Ba	permit. Pages Department of Important: If i any injury or once	7.	21. Signature of Funeral Service	Licensee		2	David A.	Burd	ock	Funeral	L Home,	P.A.	4
			23a Part Enter the disease of	complications that	saused the death	Do not ent	21 N. Se	cond	St.,	Uak Lai	nd, MD 2		Approximate
	=		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final				1000	0.	201	60			Interval Between Onset and Death
	Physician /Medical	6.3	disease or condition resulting in death)	- a CO10	nary	M	yery.	aus	,00	Ac		ye	ars
-	Examiner			A A	(or as a cons	ence of):	- 01161	72.0				J.	F
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	ience of):) I (II) e	()	Λ			400	~
	d d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cho	inic 1	Shet	motion	e Pu	ln	-anad	*u	10	45
ć	exect n and iai-tra	Exa	resulting in death) Last	Due to	(or as a consequ	ience of):						7	,
8760,	certificate be executed nding physicien and use as the burial-transit	lcal		d							1	U	
89	ifficat g phy as th	edi		201									
Вох	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnat		75-1				23d. Da	ite of deliver	у
	0 0 0	icia	in the past 12 mooths?	4 ☐ Pregi	ointh 2 ∐ Fetal nant at time of de]Ectopic pregnancy] Other (specify)				Mo	onth (Day Year
P.0	thet the de ed by the detached	hys	9 □ Unknown	9□ Unkn	own					.,			
	gned gned se de	by P	Part II Other significant condition	ogs contributing to d	eath but not resu	ilting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco use con	tribute to the	e cause of death?
ğ	w requires to been signer should be		N42/12/0	lemi	٩					1	res 2□No	3 Proba	ably 4 ∐Unknown
S	law re as be 2 sho	plet								24a. Was		Were autop	sy findings available appletion of cause of
Vital Records,	0 - 0	Completed								autop perfo	rmed?	death?	2 No
ital	icien: Th certificate rector, pag	e e	25. Was case referred to medica					26. Place	of Death	(Check only o			
	S 2 5	ToB	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2 🗍 l	ER/Outpatier	nt 3 DOA Othe	er: 4 🗀 Nur:	sing Hom	ne 5 Resid	dence 6 Oti	ner (Specify)
J of	ng Ph		27. Manner of Death	28a. Date		28b. Time o	f 28c. Injury Work	at k?	2	8d. Describe	now injury occur	red	
<u>ō</u>	Attending r death. sctor: Alter	atic	2 Accident investi	gation				Yes 2 □ N	10				
Division	r Att	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place	of Injury - At ho ing, etc. (Specify	me, farm, st	eet, factory, office		2	8f. Location (S City or Tox	Street and Numi vn. State)	ber or Rural	Route Number,
	ital o	O											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dicai	29a. Certifier (Check only one)	g Physician: To the Examiner: On the b	asis of examinat	wladge, deal ion and/or in	n occurred at the time vestigation, in my or	te, date and pinion, death	plant a h occurre	nd due to the id at the time,	causu(s) and in date and place,	and due to	the cause(s)
	thin 2	Mec	29b. Signature and title of certifie		ner stated.	0	29c. License	number	-		29d. Date signe	ed (Month, D	Dav. Year)
)	F 3 F 8) Daniel	AR.	1.	he h	N			-	/ `.	3/0	
		, 1	30 Name and address of	who complained	serry!	230) 77 =	D64:	302			1/0	010	0
		6	30. Name and address of person Dr. Daniel Bud		-		•	001-1 -	nd.	MD 215	50		ļ
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signal		4th 3t.,	Vakia	α,_	ED 215	JU		
	Registr		JUL 2	5 2008	De Sante	A A	hecks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of N	Maryland	/ Depa	artment <i>rtificate</i>	of He	ealth ar Death	nd Mer		iene	/ LI LI X	25203
		-0	Decedent's Name (First, Middle)	, Last)							Date of Deatl	h		3. Time of Death
	Physici /Medic		Frederic Botel	er Rudy							Month 7 / 2 1	Day L / 20	Year 08	12:50 am
	Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, To	own, or L	ocation of [Death		_	ounty of Death	
3			South River He						gewate				Anne Arı	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	t birthday) Yrs.	If Under 1 Months [Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)		lace (State or Foreign etry)
i	Director		214-82-0518 Usual Residence of Decedent		70	113.					2/19/19	938	Washi	ington, D.C.
	land ow		10a. State 10b. County		10c. City, T	Γown or Lo	cation						1	0d. Inside City Limits
	Mary fled a	호	MD Anne	Arundel	Edge	water	r							1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number	II GIIG I	Даве	, wate.	10f. Zip C	ode			10	Og. Citize	en of What Cour	ntry?
	th with		144 Washington	Road				21	037			U.S	. A .	
	ems ems	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. \	Was Deceder f Yes, specify	nt of His	panic Origir . Mexican. I	n? (Specify Puerto Rica	Yes or No-		4. Race - Americ Black, White,	
9	or It	F.	1 Never Married 2 Marr	ed 1 Tes 2 If Yes, Give	No No		I∐Yes 21		Specify:		,,		Specify:	
8	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date									Wh	ite
Maryland 21215-0036	"nat	Completed	15. Decedent (Specify only highes	's Education it grade completed)		(Give	lent's Usual (kind of work DO NOT use	done du	ırina most o	of working		16b. Kind	d of Business/Inc	dustry
7	withir ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4d	or 5+)		er Wor	,					N/A	
р Б	filed Hygi other		17. Father's Name (First, Middle,	Last)		MEAG	SI WOI		18. Mother's	s Name (Fi	rst, Middle, N	faiden S		
an	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be	Frederic Oren	Rudv					Ruth	Maxi	ne Goo	odma:	n	
ary	shou ind M mar umat	-	19a. Informant's Name/Relations			19b. Mailin	g Address (5	Street ar					Town, State, Zip	Code)
Ž	alth a		Myralee Fisher	. Sister		6700	Terra	A1t	a Dr.	. Lan	nham, N	1D 2	0706	
e,	of He		20a. Method of Disposition		com	e of Dispo	sition (Name natory or oth	of	i	Date			ation - City or To	wn, State
altimore,	Page nent int: If		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		te				i	7/23/	2008 A	11ex	andria,	VA
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of runeral Service	icensee			. Name and							imore Ave.
<u> </u>	8 2 E 8 9		sen by	7-6-		Ga	sch's	Fun	neral	Home,	P.A.	Ну	attsvil]	Le, MD 20781
4	Physician /Medical Examiner	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a. Athe Due to (or	YO SCIE	nce of):	r (a	ind	1'0 V	rosa	lar.	cliz	Pa Fo	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	dical	resulting in death) Last	Due to (or	as a consequer	nce of):								
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal de t at time of deat	eath 3	Ectopic preg Other <i>(spec</i>					23	Bd. Date of delive Month	ery Day Year
ري ص	s that ined t	by P	Part II. Other significant condition	ons contributing to death	but not resultir	ng in the ur	nderlying cau	se giver	n in Part I.		23e. Did tob	acco us	e contribute to th	ne cause of death?
Vital Records,	w require been sig should b	d be	Cerebral	Palsy						_	1 ☐ Ye	s 2	No 3☐ Prob	ably 4 ⊠Unknown
ပ္က	aw requ s been 2 should	Completed	Multiple.	Deub	n' FILL	Dic	ers				24a. Was ar		24b. Were auto	psy findings available
ď	The I	mo	Osteomy								autops: perforn		death?	mpletion of cause of 2□ No
ţ		Be C	25. Was case referred to medical						26. Place of	f Death (Ci	heck only one		11163	2,140
	Physician: The lav this certificate has al director, page 2	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2 ER	R/Outpatien	t 3 DOA	Other	4 Nursi	ing Home	5 ☐ Reside	nce 6	☐Other (Specif	y)
0	Attending Ph or death. rector: After th by the funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of I (Month,	njury 28 Day Year)	3b. Time of Injury	280	. Injury Work?	at ?	28d.	Describe ho	w injury	occurred	
<u>0</u>	Attendile death. ctor: A y the fu	atic	2 ☐ Accident investig	ation			М		es 2∐No)				
Division or	- # G = -	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	nod 26e. Place of	injury - At home etc. (Specify)	e, farm, str	eet, factory, o	office		28f.	Location (Str City or Town		Number or Rura	d Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basis and manner	s of examination	edge, death n and/or in	occurred at vestigation, in	the time n my opi	e, date and inion, death	place, and occurred a	due to the ca at the time, da	ause(s) a ate and p	and manner as so place, and due to	tated. the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier				29c. 1	License		r 7	29	d. Date	signed (Month,	
	(4)				4~0~			$D = \frac{c}{c}$	5065	20		- 7	1 - 21 -	2008
	ge			Deale	churc	chto	٠,	yon	, C .	Dea	rone	m	D 20	075
Γ	Sta	_	31. Date filed (Month, Day, Year)	32. Regi	strar's Signatur	e								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2008 **Physician** A^{M} 7:10 Florence L. Roge July 20, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House-Montgomery Hospice Rockville Montgomery 8. Date of Birth (Month, Day, Ye Feb. 15, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1929 New York Months Days Hours 1 □ M 2 🛱 F 79 099-22-3244 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Maryland | Montgomery North Potomac 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14908 Coles Chance Road 20878 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【本No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify. þ White 3 XWidowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) and Mental Hygiene. Is marked other than the Executive Secretary I.B.M. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Francis Lulley Rodgers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: If item 27 is any Injury or other tra once. Michelle Sullivan 17348 Founders Mill Drive, Rockville, MD 20855 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or oth Metropolitan July 25 1 | Burial 2 X Cremation 3 Removal from 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 Crematorium 21. Signature of Euneral Service L 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Her the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock the art failure. List only one cause on each line.

Imm diated ause (Final disease or condition resulting in death)

a. Colon Cancer

Die to (cross assessment) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diocace or irrur) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier July 20, 2008 Wille D64615

DHMH 17 Rev 1/2001

State

Registrar

M.D., 1355 Piccard Dr., Suite 100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

Genevieve Wroblewski,

22

2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0747 AM 2008 0 VILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTBOMEN WASHINGTON ADVENTIST HOSPITAL ARONA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Jan. 8, 1930 9. Birthplace (State or Poreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days New York 106-22-9844 1**X** M 2□ F 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marianal Event and the natural at once. Maryland Prince George's College Park 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 United States 9717 Narragansett Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14∑1Yes 2 □ No If Yes, Give Year or Dates 1948-1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dept. of Defense Cryptanalyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Reilly, Sr. Helen Luff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia A. Reilly -wife 9717 Narragansett Parkway College Park, Md. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 7/22/2008 Silver Spring, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 21. Signature of Tuneral Service Licensee 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROSCIEDOTIC CARDIOVASCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 □Yes 2 ZNo 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 ANe After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 □Yes 2 □ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Blanche Alberta Sumler 7:20P^M 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Chase Nursing Home Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Days Hours 579 26 3664 86 Yrs Director D.C. 10/30/1921 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Directo D.C. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö must be 4021 9th St. NW ed other than "natural", or Items 23a event, the Medical Examiner must b 20011 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) United College (1-4or 5+) Domestic Catholic House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil tment of Health and Mental F tant: If Item 27 is marked of Donald Perry Blanche Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Boyd DAUGHTER 4021 9th St.NW #207 Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Park 07/12 2008 4 Donation 5 ☐ Other (Specify) Riverdale, Maryland Signature of Funeral Service icensee 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 3005 12th St. NE Washington,DC 20017 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death YR mmediate Cause (Final isease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛱 No Month 4□Pregnant at time of death N/A 5 Other (specify) ed by the a detached f 9☐Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYPERTENSION cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√☐ Unknown Completed PRESSURE ULCER 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2X No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1X Natural 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 07/14/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi 15225 Shady Grove Rd Rockville, Maryland 20850

DHMH 17 Rev 1/2001

State Registrar JUL 2 3 2008

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/giene Reg. No.	2	0	0	8	2	5	2	0	
rieg. No.									

Physician
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, the Medical Evancher must be retitled at agree once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

Registr

1 - State Registrar			,	Ce	rtificat	e of L	Death			Reg. No	, 21	708	25	21
1. Decedent's Name (Fil	st, Middle, La	ast)						2	2. Date of Dea Month	ath Da	ay	Year	3. Time o	f Death
KATHLEEN				SEI	LER				JULY	18		2008	1:00	P
4a. Facility Name (If not	institution, gi	ve street and num	nber)		4b. City,	Town, or	Location	of Death		40	. Count	y of Death		
FREDERIC				l4 h l-4h -l		DERI	CK If Under	24 Hrs T (Date of Bird			DERIC	K place (State	or For
5. Social Security Number 216-03-9368 Usual Residence of Dec	3	Sex 1 □ M 2 2 3 F	7. Age (In yrs.) 93	Yrs.	Months	Days	Hours	Min	3. Date of Bird (Month, Da uly 21	y, Year	914	Cou	ntry) 1land	or ror
	. County		10c. Cit	y, Town or L	ocation								10d. Inside C	ity Lin
Maryland 1	Frederi	ick	Fre	deric	k								YOYes	2 🗆
10e. Street and Number					10f. Zip						itizen of	What Cou	intry?	
915 Motter	Place	T 40 144 - D	Lead Processing St.	0 140		21701			it. Van an Na			Amor	ican Indian,	
11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	2 🔯 No e	5. 13	if Yes, spe 1 □ Yes		Specify		ify Yes or No ican, etc.)			ack, White,		
(Specify o		rade completed)		(Giv	edent's Usu e kind of wo DO NOT u	rk done o	during mo	st of working	,	16b. k	Kind of E	Business/Ir	ndustry	
Elementary/Secondar	y (0-12)	College (1-	4or 5+)		maker		,			Ov	on h	one		
17. Father's Name (First	, Middle, Las	:t)					18. Moth	ner's Name (First, Middle,	Maide	n Surna	me)		
George S.							Fr	ances	Herma	n				
19a. informant's Name/ Nancy Seile				19b. Mai 915	ling Address Motte:	(Street	and Numb	ber or Rural Frede	Route Numberick,	er, City Mar y	or Town ylan	n, State, Zi d 2	ip Code) l 70 l	
20a. Method of Disposit 1 ☐ Burial 2 🛣 Cr 4 ☐ Donation 5 ☐	emation 3		State	emetery, cre	osition (Nai ematory or d Crema	ther plac	· .	7-22-				•	own, State Iaryla i	nd
21. Signature of Funera			1.		22. Name ar	nd Addre	ss of Facil	lity Stau	ffer F	uneı	ra1	Home		
23a. Part 1. Enter the di	Call	ule (alla						e, Fre		ick,	Mary	y Land Approxima	21
disease or condition resulting in death) Sequentially list condition and the condition of	ons, iate	b	or as a conseq or as a conseq or as a conseq	uence of):	U				On					
IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		irth 2 🗀 Feta ant at time of c	I death 3	□ Ectopic p		у					ate of deli	very Day	Year
Part II. Other significan	t conditions	contributing to de	ath but not res	ulting in the	underlying o	ause giv	en in Part	I.			use co	ntribute to 3 ☐ Pro	the cause of	death
25. Was case referred t	o medical						26 Dios	on of Dooth	24a. Was auto perfo 1 🗆 Yes	psy ormed? 2x N		prior to c death?	topsy findings completion of 2 \(\sum \text{No}\)	s avail cause
examiner? 1 Yes 2 No		Hospital:	npatient 2 🗆	EB/Outnatio	ent 3 🗆 D	OA Oth	or:		e 5⊟Resi		6 🗆 0	ther (Snec	rifu)	
27. Manner of Death	☐ Pending investigation	28a. Date of (Mont	of Injury h, Day, Year)	28b. Time Injury		28c. Injur Worl		21	3d. Describe			(-)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Could not I	be d 28e. Place buildir	of Injury - At hong, etc. <i>(Specil</i>	ome, farm, s	treet, factor	y, office		21	3f. Location (City or To	Street a wn, Sta	and Nun te)	nber or Ru	ral Route Nu	mber,
		hysician: To the amine: On the ba and mann	asis of examina											(s)
29b. Signature and title	of certifier	Am	,	מת ו	29	c. Licens	e number	291		29d. D	ate sign	ned (Month	n, Day, Year)	
30. Name and add ss 31. Date filed (Month, D	Pay, Year)	A21	2 Ma	D. E	Print)	To	esp	ton	e A	ve		Ene	den 217	je

			State of Maryland / D State of Maryland / D State of Maryland / D	epartment of He Certificate of De	ealth and M eath	lental Hygid Reg	ene 2008	25208
	Physicia		1. Decedent's Name (First, Middle, Last) Ruth Louise Stenger			2. Date of Death Month	Day Year	3. Time of Death
**	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death		4c. County of Death	
			Washington County Hospital		rstown	C. Data of Disth	Washingt	ON lace (State or Foreign
H	Funeral Director		5. Social Security Number 219-12-2021 6. Sex 1 □ M 2□XF 7. Age (In yrs. last birtl		Hours Min.	8. Date of Birth (Month, Day,) May 14,19	Year) Coun	otry)
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	r 28a-	Directo	Maryland Washington W 10e. Street and Number	illiamsport 10f. Zip Code		100	g. Citizen of What Coun	itry?
	23a o		10715 Hoffman Drive		795		USA	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ⋈ No	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spo , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Marical Evanting on the motified at	by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 □ Yes 2 X No	Specify:		Specify: W	hite
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	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		8. Mother's Name	e (First, Middle, Ma		/
Maryland	should be f and Mental I s marked ol umatic eve	10	Robert Leo Eichelberger			ne Louis		
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Box	death e atte	iciar	in the past 12 months2 1 Ves 2 Petal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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Division of Vital Records,	w requir s been s should	Completed by				24a. Was an	24b. Were auto	psy findings available
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<u>d</u>	Physia this cral dire	၉	1 ☐ Yes 2 ☐ HOSpital: 1 ☐ Impatient 2 ☐ ER/Out		4 🗆 Nursing Ho	me 5 Residen	nce 6 Other (Specif	(y)
on	ding Ph th. : After th : funeral	tion	227. Marinet deserting 2	njury Work?	es 2 🗆 No	28d. Describe now	rinjury occurred	
N S	r Atter er dea rector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (Stre	eet and Number or Rura State)	al Route Number,
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge (2 ☐ Medical Examiner: On the basis of examination and manner stated.					
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License r		29	d. Date signed (Month,	1
			maous, M		588	1	uly 23"	,2008
K	4-5		30. Name and address of person who completed cause of death (Item 23a) (JUDITH TIBAOUA TID. 251 E.	Type, Print) Anhelan	57 14	teresor	own TID	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	0	1	
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			1. Decedent's Name (First, Middle, La	ast)				ate of Death	Day	Year	3. Time of Death
	Physici /Media		John Leroy Sc	wers				ılv		2008	6:33 A M
	Examir		4a. Facility Name (If not institution, gi			4b. City, Town, or Locat		,	4c. County of	of Death	
п			1048 Mt. Aetna	Rd.			stown_			Wash	ington
	Funeral		,	Sex 7.Ag XXM 2□F	e (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	urs Min. 8. Da	ate of Birth fonth, Day, \ / • 27,	(ear)	9. Birthpl	ace (State or Foreign try)
板	Director		219-12-0069	7CA(W) 2	85 Yrs.		Nov	1. 21,	1922	Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10	Od. Inside City Limits
	Maryl f sho	ö	Maryland Washi	naton	На	gerstown					1 X Yes 2 □ No
	28a	Director	10e. Street and Number		110	10f. Zip Code		100	g. Citizen of W	/hat Count	try?
	3a ol	0	1048 Mt. Aetna	Rd.		21740)		US	AS	
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanio If Yes, specify Cuban, Mer		es or No-	14. Race	- America k, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, Ira Medical Exacities must be rectified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Ares 2 1 If Yes, Give Year or Dates:	14/15	VV	ecify:	, 810.)	Specify:		ite
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altimore,	permit. Page Department of important: If any injury or once.		* 4 □ Donation 5 □ Other (Spec 21. Signal re of Funeral Service Lie	/-/-	Greenlawn	Mem. Park Sborne Afrener	July 25.	2008	Willian	nspor	T, Marylan
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5			23a. Part T. Enter the deease, or con	nplications that caused	the death. Do not en					,	Approximate
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Вох	eath certifi attending for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Mon	e of delive nth	ry Day Year
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	Physic this ce al dire	일	1 Yes Yo	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA Other: 4□	Nursing Home	Hesiden	ce 6 □Othe	or (Specify)
П	ding Ph h. After th funeral	i.	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) lnjury	Work?		Describe how	injury occurre	ed	
sio	Attending Physician: ir death. actor: After this certific. by the funeral director.	cati	2 Accident investigated	ne l		M 1 Yes					
Division of	or At after of Dirac in by	Certification;	4 Homicide determined		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		ocation (Stre lity or Town,		er or Hurai	l Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	f examination and/or in	ivestigation, in my opinion,	, death occurred at	the time, dat	e and place, a	ind due to	the cause(s)
	Mithir To th	ž	29b. Signature and title of certifier			29c. License num	ber	290	d. Date signed	(Month, L	Day, Year)
			Dues 1 K	engi	4P	7002	6526	Ti	15 25	3,20	DO 8.
,			30. Name and address of person who	complete duse of o	leath (Item 23a) (Type,	Print) Medinal	110010	Mn	HXA	EIL	DIN
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 8:00 PM Mae Hazel Swann July 17, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Hermitage at St. Johns Creek Solomons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/02/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👿 F Maryland Director 90 217-14-7305 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐YNo Director MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13325 Dowell Road 20629 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education Pages 1 and 2 should be filed vent of Health and Mental Hygirant: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Armiger Gertrude Chaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hall, Daughter 3467 Chaneyville Road, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State So. Memorial Gardens 07/21/2008 4 Donation 5 Other (Specify) Dunkirk, MD 22. Name and Address of Facility In the of Funeral Service Licens Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final ATHERO SCLEROTIC HEART DISEASE Y Dors Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burial-Division or Vital Records, P.O. Box 68760 the attending physician thed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEVERE DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform this certificate or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Menny of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 MD prician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANWAR MUNITI M. D. 110 HOSPITAL RD PRINCE FREDERI 1010 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 1 2008

Registrar DHMH 17 Rev 1/2001

			For	State o	f Maryland		artment of H			7 (800	25211
			Registrar 1. Decedent's Name (First, Middle	(act)		Cer	lilicate of L	Jealii	2. Date of De	Reg. No. C	700	3. Time of Death
	Physicia	an	Nancy	, Lasij	Lee	2	See		Month	Day 20	Year ∩ 8	M
jakon. Kona	/Medic		4a. Facility Name (If not institution	give street and nur				Location of Death		7/	y of Death	2:30 P "
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	as <i>t birthday)</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05/26/			lace (State or Foreign
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	the N 28a-1 notifi	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a or		14515 Ell	erslie Ro	ad			21529			USA	
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215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:	16a Dece	dent's Usual Occup	ation		16b. Kind of I		nite
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<u>Ja</u>	should be and Mental marked c	To E	Virgil		Pr	inty		Cather	ine 		Barno	cord
Maryland	C/ 10 m 10		19a. Informant's Name/Relations		1		ng Address <i>(Street</i> 15 Ellers					'
	es 1 and of Health item 27 rother t		Richard D. See	/ Husband			osition (Name of	TIE MORG	Date	20c. Location		
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. =	Physician	9	Immediate Cause (Final disease or condition			TIC /	RECTAL	CARCIA	NMA			Onset and Death
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X	leath certific attending p I for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna		⊒Ectopic pregnanc	,			ate of deliv	
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ē	ilcian: Th certificate ector, pag		25. Was case referred to medica	1				26 Place of De	1 Yes ath <i>Check onl</i>		1 ☐ Yes	2 No
or Vital	Physician: The raths certificate har al director, page	o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	0.51	Home 5 XRes		ther (Speci	fv)
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ö	Attending r death. ector: After by the funer	atio	1 Natural 5 ☐ Pendii 2 ☐ Accident invest	gation	in, buy reary	,,		Yes 2 □ No				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ	ained Zoe, Place	e of injury - At ho ling, etc. (Specif	ome, farm, st	reet, factory, office			(Street and Nur own, State)	nber or Rui	al Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th g882 8-13-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LOUIS ST.MARIE 07 13 08 0512 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Social Security Number 127 - 24-5456 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**⋈** M 2□ F 024-27-5458 Director 76 November 21, 1931 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 28a-f show 1 XYes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 86 E. Main Street with ral", or items 23a Examiner must U.S.A. by Funeral 21532-Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1952 If Yes, Give Year or Dates: 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Completed er than "natur the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked traumatic e Louis P. St. Marie, Sr. Blanche Larrivee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Jeanne St. Marie 21532-86 E. Main Street Maryland Department of Health Important; If item 27 any Injury or other the once. Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's Cemetery July 16, 2008 Maryland 4 ☐ Donation 5 ☐ Other (Specify) Flintstone 21. Signature of Funeral Service Licen 22. Name and Address of Facility John 7 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode, or heart failure. List only one cause on each line.

Indeed, or heart failure. List only one cause on each line.

Indeed, or condition resulting in death)

a. DISECTIC ACRIT ARCH ANSURYSM. Approximate Interval Between Onset and Death Physician ما در ONE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to for as a consequence of Physician/Medical Examiner If any, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Y*e*s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred After Injury at Work? 5 ☐ Pending investigation 1 Natural nours after death.

neral Director: A
y filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours To the Funeral 1 🖫 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 5+ 1486 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memoria Mds BArrera

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 4 2008

sarke

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Amended #29d, nls,

per phy., 07/22/08,

Allegany Co. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:10 AM Stewart atherin 2008 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Garrett Coochwill Nursing Home Grantsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Days 33 503-16-5438 September 4,1919 Director South Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Garrett Grantsville Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 39 U.S.A 21536 Killdeer 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Womestic Homemaker th and Mental Hw 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any Injury or other traumatic ev Catherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 Tolstoy lane, Severna Park, Maryland 21146 Freek Form Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition D*a*te July 22, 2008 1 Burial 2 Cremation 3 Removal from State Comberland, Maryland Cumberlanch Crementory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Fureral Home, 57 Front Ava, Frontburg, MD 21532 1. holes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) spiralor **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-transit neumon Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🛣 No 24a. Was an 2M No al or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00661 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Suit 204 Nace em TIRS 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

3	Funeral Director		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	
	Physician		
1	Physician /Medical Examiner		
1.		er	
Division or Vital Records, P.O. Box 68760,	if or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit	ertification: To Be Completed by Physician/Medical Examiner	

1 - For State Registrar

Physician /Medical Examiner

sicia			(First, Middle, Last) Catherine	e Smith					2. Date of Deat July	-	20 ^v 0°8	3. Time of Death 5:35 p _M
edic min	403	4a. Facility Name (If Montgor	not institution, give s mery Vil	treet and number) lage Hea	lth Ca		y, Town, or Location			4c. Cou MC	inty of Death ntgom	ery
ral or		5. Social Security Nu 578-24-3		м 2 Х F 7. Age (In yrs. last bir 4	Yrs. If Und			8. Date of Birth (Month, Day, July 1	Year) 19	9. Birthp Cour 14 Was	place (State or Foreign htry) Sh. DC
		Usual Residence of 10a. State	Decedent 10b. County	1	0c. City, Tow	n or Location					1	Od. Inside City Limits
	to	MD	Howard			t Airy						1 □Yes 2 🛣No
	Funeral Director	10e. Street and Num	alvin Br	anch Ct.		10f. Z	ip Code 21771		11	0g. Citizen USA	of What Cour	ntry?
	Funer	11. Marital Status	ied 2□ Married	2. Was Decedent Eve Armed Forces? 1 Yes 2 No	er in U.S.	If Yes, sp	edent of Hispanic decify Cuban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
	þ	3 X Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠No Spec	cify:		Spe	ecify:	
	letec	(Speci	15. Decedent's Educ ify only highest grade		16a.	Give kind of v	sual Occupation vork done during n use retired)	nost of worki	ing	16b. Kind o	of Business/In	dustry
	Be Completed	Elementary/Secon	ndary (0-12)	College (1-4or 5+)		Stock				Dist	ribut	ing
	To Be C	17. Father's Name (Howar	(First, Middle, Last) d Beaver	s				other's Name	(First, Middle, M	Maiden Sur	rname)	
		19a. Informant's Na Shirle	ame/Relationship (Type y Story/	daughte	r 2	. Mailing Addre 145 Ca	ss <i>(Street and Nu</i> llvin Br	mber or Rura	al Route Number	City or To	own, State, Zip Lry MD	21771
			oosition ☐ Cremation 3 ☐ Re 5 ☐ Other (Specify)	emoval from State	cemete	f Disposition (N ry, crematory o dale C	ame of r other place) cemetery	7/2			on - City or To insbur	own, State Cg, WV
ouce.		21. Signature of Fu	Ineral Service License			22. Name 917	and Address of Fa	rv Rd	sedale . Mar	Fune	eral H	Home VV 25404
Ħ		23a. Part1. Enter the	he disease, or complice int failure. List only on	cations that caused the cause on each line.	e death. Do							Approximate Interval Between
an .		immediat Cause (disease or condition resulting in death)	Final	Cor	1000	tive	year.					Onset and Death
al er		resulting in doctiny		Due to (or as a c			,					
	niner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or in the cause of the cause)	eriving	Due to (or as a c		of):	. 10		1200		Dire.	
	Examiner	Cause (Disease or that initiated events resulting in death) L	Last	Due to (or as a c	consequence	OI).	tens	1	2111101	1412	Diregi	<u> </u>
	edica		d		14	2 he	((()))	(CO)				
	ysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	3c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	n 3 ⊟Ectopic 5 ⊟ Other				23d.	. Date of deliv Month	rery Day Year
	Be Completed by Physic	Part II. Other signif	ficant conditions con	tributing to death but	not resulting i	n the underlying	g cause given in Pa	art I.	23e. Did tol	\	contribute to t	the cause of death?
	olete								24a. Was a		24b. Were aut	opsy findings available
	Com								autops perfor 1∐ Yes	med? 2 XNo	death? 1 ☐ Yes	ompletion of cause of
		25. Was case reference examiner?	1	ospital:	2000				h (Check only on		70	
	n: To	1 ☐ Yes 2 27. Manner of Death	th	28a. Date of Injury	28b.	tpatient 3□ Time of Injury	28c. Injury at Work?		me 5 Reside			ify)
	catio	1 ⚠Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be			M	1 ☐ Yes 2		001 001			I Pout Monto
	Medical Certification:	4 ☐ Homicide	determined	28e. Place of injury building, etc.	(Specify)	arm, street, ract	ory, office		City or Tow	n, State)	umber or hur	ral Route Number,
	dical	29a. Certifier (Check only one)		sician: To the best of ner: On the basis of e and manner state	xamination ar							
	Me	29b. Signature and	title of certifier	ant		2	29c. License numb				igned (Month	
		30. Name and addr	ress of person who co	mpleted cause of dea	th (Item 23a)	(Type, Print)	DAILE	<u> </u>		301	7 94	105081A 5008
		160	Nti 10	1529	Dac	1	Drive	6	cheo	(4 /cc	un M	15807 du
Sta	te	31. Date filed (Mon	nth, Play Year 5	32. Registrar	s Signature	1 Ano	100					,

Registrar

			1- For Amend 23a, PIState of Maryland / Pent Registrar Cell	artment of Health and Mental Hy rtificate of Death	/giene Reg. No. 2008 25215	1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be not event.		Decedent's Name (First, Middle, Last)	2. Date of D Month	eath 3. Time of Death Day Year	٦
*		-	Richard C. Saxon	July	7, 2008 6:30 A ^M	
		-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
		. 9	Larkin Chase Nursing Home	Bowie	Prince George's	4
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Yrs. 73		Pay, Year) Country)	
			250-42-1159 Table 73 Yrs.	Sept 3	30, 1934 South Carolina	4
			10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits	
		ctor	Maryland Prince George's Upper Ma	arlboro	1X Yes 2 □ No	
		Jire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
		Funeral Director	374 Harry S. Truman Drive	20774	United States	_
	tems	nne		Was Decedent of Hispanic Origin? (Specify Yes or N if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. African	
36	iin 72 hours afte "natural", or ii Aedical Examin	by F	1 ☐ Never Married 2 ☐ Married 1 █ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ₺ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: American	
21215-0036		edk	15 Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry	-
15		plet	(Specify only highest grade completed) (Give life.	e kind of work done during most of working DO NOT use retired)		
212	d with giene er tha the 1	Completed		inting Specialist	Government	
ם	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middi		
Maryland		Tol	George Saxon	Lillian Stal		_
lar	2 short and land			ing Address (Street and Number or Rural Route Num		
e,	1 and Health Sm 27 ther t		Sidney D. Saxon - Son 374 1	Harry S. Truman Dr. Uppe	r Marlboro, MD 20774 20c. Location - City or Town, State	-
آور	ages if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place) Mem. Cemetery July 14, 2		
Baltimore,	it. Partiment			2. Name and Address of Facility Stewart		-
Ba	permi Depa Impo any Ir once,		Marshall & and !	4001 Benning Road, NE Wa	shington, DC 20019	
A Company	ate be executed /Medical Examiner purish-transit the burial-transit		23a. Part . Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death	d
		8 1	Immediate Cause (Final disease or condition as with a disease	lure Uremia	- John and Board	1
			resulting in death) Due to (or as a consequence of): Renal Failure			
		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			-
		nine	Cause (Disease or injury that initiated events C.			
,		Examiner	resulting in death) Last C. Due to (or as a consequence of):			_
8760,		ical	d			
မွ	tificat ig phy as th	Physician/Medi				7
Box	w requires that the death certific been signed by the attending p should be detached for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □	□Ectopic pregnancy	23d. Date of delivery	d
<u>с</u>		sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year	
P.O.	nat the	Phy	9 ☐ Unknown Part il. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I 23e Dir	I tobacco use contribute to the cause of death?	_
ds,	ires the signeral labe d	by	Chronic renal failure; hypertension	, , , , , , , , , , , , , , , , , , , ,	Yes 2√ No 3 Probably 4 Unknown	
Records,	The la ate has page 2	eted	onionic renar rarrare, hypercension		Λ	\dashv
3ec		Completed		24a. Wa au' pe	as an 24b. Were autopsy findings available prior to completion of cause of death?	
a			OF Was accessful to modical	1 Yes	2 Mo 1 □ Yes 2 □ No	
or Vital	Physician: this certific	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check only	sidence 6 Other (Specify)	
	<u> </u> ∓ e	: To	27. Manner of Death 28a. Date of Injury 28b. Time of	TE INDISHING TOTAL	e how injury occurred	-
ion	Attending r death. ector: After by the funer	atior	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 □ Yes 2 □ No		
Division	Atte	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)	
Ö	ital on Irs aftor Iral Di	Certification:				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, dear 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.			
	To th Within To th	Me	29b. Signature and tifle of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
			Yester-	D0045217	July 9, 2008	
			30. Name and address of parson who completed cause of death (Item 23a) (Type. Ade / Isaac / Ajayi, M.D. 6201 Greenbel	, Print) t Road #U-15 College Par	rk, MD 20740	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature,			
	Registi		AUG 0 5 2008	garles		

			Term State of Maryland / Department / Department	artment of H		Mental Hy	giene Reg. No 2008	25216
į	Physici		Decedent's Name (First, Middle, Last) BALSORAH P. SAVELY			2. Date of De Month JULY		3. Time of Death
als:	/Medic Examin		4a. Facility Name (If not institution, give street and number) 210 David Dr.	Cheste	or Location of Death	1	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 219-40-7220 G. Sex 1 M 2 M F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 1	ay, Year)	rthplace (State or Foreign ountry) SSISSIPPI
Baltimore, Maryland 21215-0036	ne Maryland 8a-f show otified at	Director	10a. State 10b. County 10c. City, Town or Lo MD Kent Chestert	town				10d. Inside City Limits 1 XYes 2 No
	ath with t s 23a or 2 nust be n	ral Dir	210 David Dr.	10f. Zip Code 21620	-		U.S.A.	·
	be filed within 72 hours after death with the Marylar and Hygiene. ad oth Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Span, Mexican, Puerti	pecify Yes or No o Rican, etc.)		
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) [Give life. In the complete of the com	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	16b. Kind of Business Own Ho	•
	be d all	To Be C	17. Father's Name (First, Middle, Last) Lucius Lamar Patterson	TOMOS TO			, Maiden Surname) Craine Ri	ley
	es 1 and 2 s of Health ar f Item 27 is ir other trau		Anne S. Warhurst (daughter) 21 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	11 E. Ca	ampus Av	ze. Che	20c. Location - City o	MD . 21620
Бапп	permit. Pag Department Important: I any Injury o once.		4 Donation 5 Other (Specify) Kent Cr 21. Signature of Fulleral Service Lidensee M00510 1	2. Name and Addre	ess of Facility uneral	1/08 Home o	Smyrna, f Stephen lena, MD.	L Schaech
Hecords, P.O. Box 68/60,	Physician /Medical Examiner be executed burial-transit sthe burial-transit	dical Examiner	23a. Part I nter the 18 state, or complications that caused the death. Do not ent shock, or heart illure. List only one cause on each line. Immediate Cause (final disease or conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2. CHOVIC TO Due to (or as a consequence of): b. Lue to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	the death certific y the attending p	Physician/Me		Ectopic pregnanc Other (specify)	у		23d. Date of do Month	elivery Day Year
	s Hospital or Attending Physician: The law requires to 24 hours after death. s Funeral Director: After this certificate has been signe etely filled in by the funeral director, page 2 should be e		Part II. Other significant conditions contributing to death but not resulting in the un		en in Part I.		tobacco use contribute Yes 2 No 3 11	to the cause of death? Probably 4 ∐Unknown
		Completed by	DEMENTIA			1□ Yes	psy prior to death? 2√1No 1 □ Ye	
		ation: To Be	25. Was case referred to medical examiner? 1	28c. Injui		ome 5 ⊠ Resi	one) idence 6 □Other (Sp how injury occurred	ecify)
DIVISION		fedical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, structure building, etc. (Specify)			City or To		
			29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death of the	vestigation, in my	opinion, death occu	, and due to the rred at the time,	, date and place, and du	ue to the cause(s)
	To the within To the Compl	Σ	29b. Signature and title of certifier A A A A A A A A A A A A A A A A A A A		0415 8	7	29d. Date signed (Mor	131108
			30. Name and address of person who completed cause of death (Item 23a) (Type, Helen A. Noble, M.D. 122 Speed 31. Date filed (Month, Day, Year) 29. Registrar's Signature	,	hesterto	own, MI	21620	
	Sta Registr		AUG - 5 2808	27				

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Director

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Department of H
Important: If iter
any Injury or ott

altimore, Maryland 21215-0036

Physician /Medical Examiner

physician and the burial-transi as attending use for the detached signed by page 2 should certificate has I or Attending Physician: after death. Director: After this certifica funeral director

Division or Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 2008 Franklin Stowell 2:26 P M July 24 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Moran Manor Nursing Westernport Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Oct. 28 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months 219-44-0490 1 M 2 □ F 64 Days Hours Min. 1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV. Mineral Keyser 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26726 Rt. 1, Box 182 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Vietnam Year or Dates: Vietnam 1 □ Never Married 2 □ Married white 1 ☐ Yes 2X No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Steel Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Stowell SR Lottie Mae Ford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Brown/daughter 17409 Mt. Savage Road, Frostburg, Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Flintstone Maryland MD. Veterans Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Mana 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acuto w hum conons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Milletus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1□ Yes 2□No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only end manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21284 12008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD. 21532 31. Date filed (Month, Day, Year) JUL 2 5 2008 32/Registrar's Signature Registrar

within 24 hours a To the Hospital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 926 1 08 EDWARD B. SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Willsmico SAUSKING MADINA REGIONAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Pay, Year) 1/17/1954 9. Birthplace (State or Foreign **Funeral** Days Months 1**X** M 2□ F 54 Virginia Director 214–60–8733 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 XNo Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2172 Old Snow Hill Road 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. th and Mental Hygiene. 7 is marked other than "natural", or items traumatic event, the Medical Examination Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced white Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) student education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mollie Ramsey Richard B. Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tragonce. 2172 Old Snow Hill Rd., Pocomoke City, MD 21851 Mollie Wright (mother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State Woodbine Cemetery 7/25/2008 Harrisonburg, VA 4 ☐ Donation 5 ☐ Other (Specify) Professional Association 103 Linden Ave., Procomoke City, MD 21851 21. Signature of Fune al Seryce Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 36 hrs tatus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Drie to (or as a consequence of): Sequentially list conditions, Examine and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physician and ts the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed ANOX! C Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 1 Yes 2 1 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ⊟No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 - Natural after death.

I Director: Ald in by the further 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Function (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00041211 , our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbury MD 21801 BA 10 P.R.M.C MD ernando 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 3 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** M July 19 2008 1749 Edward Justin Sanbourn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** Hours Year) Days Months Sept 10, 1922 Massachusetts 028-16-8243 85 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once. 10a, State YMi Yes 2 ☐ No Director MDMontgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 20895 3620 Littledale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No IfYes, Give Year or Dates:1942-45 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Justina Kavanaugh Hugh Edward Sanbourn ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19801 Shady Brook Way Gaithersburg, MD 20879 Patricia L. DeVault/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Chesapeake Crematory | 07/23/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Sing Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licer Approximate Interval Between Onset and Death MO1251 Beverly L. Heckrotte, P. dlarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratery arreshock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a Atheroscler tic Heart Disease
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner b. Anemia Sequentially list conditions, if any, leading to immediate cause. Errier Unidentifing Cause (Disease or injury that initiated events Due to (or as a consequen w of): Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Munbourn, Edward 1/19/08 1749 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Prostate Cancer 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 XNo Right Hip Fracture 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yos 2 □ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 07/17/08 12:00 PM trip and fall 1 ☐ Yes 2X No 2/Accident l or Attend after death Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
35515ted Living 28f. Location (Street and Number or Rural Route Number, 362) 97 Town State ale Rd. Censington, MD 4 ☐ Homicide Hospital of 24 hours a Funeral D 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D53691 July 20, 2008 10/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D. 6320 Democracy Blvd. Bethesda, MD 20817 Year) 31. Date filed (Month,

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 1659 M Physician BRUCE 19 STOKES July 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) Oct. 21, 19 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F Georgia 56 Yrs. 1951 403-74-5840 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 Yes 2 No Suitland Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20746 USA 3407 Navy Day Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: African 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stokes Eddie Lee Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20746 3407 Navy Day Drive Suitland, MD (Brother) Paul E. Green 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 XCremation 3 Removal from State 7/23/08 Riverdale, MD Riverdale Park Cre 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 KIND ELSING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final may 0,-did Interestina **Physician** ma ssive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit Exami and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month for in the past 12 months? 5 Other (specify) ☐Yes 2☐No ned by the a Division or Vital Records, P.O. 9 ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 2 No 2 No certificate 1□ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

To the Hospita. — within 24 hours after death.

To the Funeral Director: After the funeral part of the fun 6

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rratts

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Soffredo 4:05pm M **Physician** 1090 e 2008 Juli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Rattimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 M 2 □ F Ghana 25 January 17,1983 213-65-2993 Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits 10a. State 10b. County 28a-f show ä a or 28a-f shot be notified a 1 ☐ Yes 2 X No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 Ghana permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a any injury or other traumatic event, the Medical Process. 442 N. Summit Avenue by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. 3 ☐ Widowed 4 ☐ Divorced B1ack Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Conference Center Services Aramark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theophilus Tagoe Milldred Eshun ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 442 N. Summit Avenue, Gaithersburg, Maryland 20877 Millicent Frimpong - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 08/09/2008 Gate of Heaven Cemetery 22. Name and Address of Facility 21. Signature of Funeral Se vic/ Li lensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Anaplastic lumphomo /Medical Due to lor as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes septic shock, renal failure. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2 No 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) 200g CylorMD 30. Nam, and a pross of person who completed cause of death (Item 23a) (Type, Print) 22 S Greene Street ay Raithmore, MD 31. Date filed (Mgnth, Day) 32 Registrar's Signature Year State 22 JUL 2008 Registrar

1 - 3	For State Registrar			ie oi ividi	yiaiiu /	Cei	rtificat	e of L	Peath				008		
1. De	ecedent's Name	(First, Middle	e, Last)								Date of Dea Month	th Day	Year	3. Time of D	
			Everet	t Blair	Terry						July	20.	2008	2306	M
4a. F.	acility Name (If	f not institutio	n, give street a	and number)			4b. City,	Town, or				4c. C	ounty of Death		
5 So	Sub ocial Security N	ourban He	ospital 6. Sex	7 Age	(In yrs. last	hirthday)	If Under		If Under		8. Date of Birth	1		gomery place (State or	Foreian
	577-03-90		1 X M 2 l	_	93	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day		Cou	intry) ict of Co	
	al Residence of									1	ounc o				
10a.	State	10b. County			10c. City, To	own or Lo	cation							10d. Inside City	
M	aryland	Mon	tgomery				-T-		ver Sp	ring				1 □ Yes 2	K NO
10e.	Street and Nun	nber					10f. Zip	Code				10g. Citize	n of What Cou		
		Suther1	and Road			10.1	Non Dean	dama of 11:	2090		a sife Vac or No	14	. Race - Amer		
	/larital Status ☐ Never Marri	od OF Mor	Arn	s Decedent Ev ned Forces?]Yes 2 ∑ No		13.	f Yes, spe	cify Cubar	, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	14	Black, White,		
3	☑ Widowed		lf Y	es, Give ar or Dates:	,		1 □Yes	2 🔼 No	Specify:	•		s	pecify:	White	
		15. Deceden	nt's Education		1.10	6a. Dece	dent's Usu	al Occupa	tion		- [16b. Kind	of Business/Ir		
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	12					Со	nstruc							Constructi	ion
17. F	Father's Name ((First, Middle,	Last)						18. Mothe	er's Name	e (First, Middle,	Maiden Si	urname)		
			eman Ter								ise M. Ha				
19a.	. Informant's Na			nt)	1		•				al Route Numbe			ip Code)	
202	Richard Method of Disp		y - Son		20b Place						rlboro, M		nd 20772 ation - City or T	own, State	
.	1 ☐ Burial 2	Cremation		I from State	20b. Place ceme				1	_	_				
_	4 □ Donation Signatene of Fu		· · · · · · · · · · · · · · · · · · ·	1	Fort		oln Cre			07/25	/2008	Bren	twood, M	aryland	
21. 3	Um	and	a	udu	Ua)	В	ines-R	inald	i Fune	ral H	lome, Inc. nue, Silv	er Sp	ring, Man	ryland 209	904
23a	. Part 1. Enter the	he disease, or rt failure. List	r comparations t only one caus	that caused t se on each line	he d⇔nh. □	o not ent	er the mod	de of dying	, such as	cardiac	or respiratory ar	rest,	Y.	Approximate Interval Betwe	
Imm	nediate Cause ((Final	2	P		MOI	nia							Onset and De	ain /},
resu	ulting in death)		(°-	Due to (or as a	consequen	ce of):									
Sequ	uentially list cor	nditions,	b												
if an	uentially list cor y, leading to im se. E. te. U. de se (Disease or initiated events	mediate rlying injury	2 '	Due to (or as a	consequen	ce or):									
that	initiated events afting in death) I	Last	c	Due to (or as a	consequen	ce of):									
			u												
	EMALE: . Was decedent	t pregnant		es, outcome o			75					23	d. Date of deli	very	
	in the past 12 1 ☐ Yes 2 ☐	months?	4 [Live birth 2 Pregnant at t			☐ Ectopic p ☐ Other (s _i						Month	Day Ye	ar
_	9 Unknown		91	Unknown										-	
Part	II. Other signif	ficant conditi	ions contributir	ng to death but	not resultin	g in the u	nderlying o	ause give	n in Part I		23e. Did to		_	the cause of de-	
											1 🗆 Y	es 2 🕦	MTO 3∏ Pro	obably 4 🗆 Ur	iknown
.											24a. Was a		24b. Were aut	topsy findings av	vailable use of
											perfor	med? 2 12 No	death?	2 □ No	
25.	Was case refer	red to medica	10.0					1.		e of Deat	h (Check only o	ne)			
1	1∐Yes 2. ₩	-	Hospita	1 Li-mpatien			nt 3 🗆 D		4 ⊔ N		me 5 Resid			cify)	
	Manner of Deat	5 Pendir	ng	i. Date of Injury (Month, Day,		b. Time o Injury	1	28c. Injury Work	?		28d. Describe h	ow injury	occurred		
	2 ☐ Accident	investi 6 ☐ Could	igation	Diagonal Inc	A h	form -	M factor		′es 2□		Of Looting (tract c = d	Number == C	ml Pouto Mum-t	or
	4 ☐ Homicide	detern		. Place of Injur building, etc.	(Specify)	, tarm, str	eet, factor	у, описе			28f. Location (S City or Tow	ureet and n, State)	ivurnoer or Hu	rai Houte Numb	⊌I,
202	. Certifier	1 Cortifui	na Physician	To the best of	f my knowle	dae dest	h occurred	at the tin	ne date a	nd place	and due to the	Callee(e)	and manner as	stated	
230.	(Check only one)		Examiner: O		examination						red at the time,				
29b.	. Signature and	title of certifie					29	c. License	number			29d. Date	signed (Month	n, Day, Year)	
	16	ca /	iss -	1/1	L	D.		000	57	03)_	07	12112	008	
30 1	Name and addr	ress of person	who complete	ed cause of de	ath (Item 23	a) (Type	Print)	,				- 1	,		
6	COOM	V KI	w Kun	ian.	4810	Ro	Icled	29 03	Dr.	Sui)- le 200,	Bet	heida	(HD2	0817
31. [Date filed (Mon			32. Registra	r's Signature	,		/							
	JUL	. 22	2008	Barren	JK.	Som	120								
				7		1	-								

State Registrar

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fleat 21s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760, Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

State Registrar

SNEEM AICHANI, 31. Date filed (Month, Day, Year) **JUL 23**

elle

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifier

SMITH 2835 gistrar's Signature

alelan

29c. License number

SUITE

203,

29d. Date signed (Month. Day. Year) 16/08

State of Maryland / Department of Health and Mental Hygiene 25224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** July 18, /Medical Thelma S. Thompson 2008 7:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2510 Fawn Lane Prince Frederick Calvert County Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 📉 F Director 239-24-2979 Jan. 7, 1923 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Calvert Co. Prince Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2510 Fawn Lane Funeral 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important; if item 27 is marked other this any injury or other traumatic event; the once. 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon G. Stirling Gladys T. Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 Fawn Lane, Prince Frederick, Maryland 20678 Earl E. Thompson (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July D24. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Vianney Cem. 2008 4 □ Donation 5 □ Other (Specify) Prince Frederick, MD 21. Signature of Finer Service Lic 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an 2 **2**00 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 00059061 July 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 6 Patel, M.D. 110 Hospital Road, Suite 212, Prince Frederick, MD 20678 State JUL 2 1 2008> Registrar

DHMH 17 Rev 1/2001

	1	State Registrar		C	ertificate of Dea	th		. No.	23223
Dhysisia		1. Decedent's Name (First, Middle, Las				2.	Date of Death Month	Day Year	3. Time of Death
Physiciai /Medica		AUDREY ARIE					07-20-2	008	9:50 A M
Examine	r '	4a. Facility Name (If not institution, give Williamsport Nur			4b. City, Town, or Locati			4c. County of Dea Washind	
		5. Social Security Number 6. S		In yrs. last birthda	Hagerstown		Date of Birth	-	thplace (State or Foreign
Funeral Director			□M 2DTE	83 Yrs.	Months Days Hou	rs Min. 0	Date of Birth (Month, Day, Y 4-11-19	25 Pe	ennsylvania
land ow	-	10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
Mary P-f eh	2	Maryland Washing	ton	Hagerst	own				1 ZYes 2 ☐ No
or 28,	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
eth w		11403 Stonecroft			21742			US	
urs a	Dy rur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:	er in U.S.	 Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 No Specify 		y Yes or No- an, etc.)	14. Race - Am Black, Whi	te, etc.
72 hc netur	ale	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. De	cedent's Usual Occupation ive kind of work done during report DO NOT use retired)	most of working	16	b. Kind of Business	/Industry
within then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retired) Ionemaker	J		Homw Ow	mer
Hygie Hygie ant.		17. Father's Name (First, Middle, Last))			other's Name (F	First, Middle, Ma		
fentel fentel rked lic ev	0 00	Clarence Mallory				Martha .	Ann Far	lint	
2 short and his ma	1	19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Nu				
and leelth m 27 her tr	1	Burtis Tyler - h	usband		03 Stonecroft				
inges 1 in its or ot		20a. Method of Disposition f E Burial 2 □ Cremation 3 □	Removal from State	Delaware	sposition (Name of trematory or other place) L'ETETANS	Date	1 20	lc. Location - City or	Town, State
it. Partmer	-	4 Donation 5 Other (Specifical Control of Funeral Service Control of Funera	9)	Memorial	Cemetery	07/24/		Millsboro	DE
Deg man		John A. Cran	1 00		Cranston Fund F O Box 967,	ral Hom Seaford	e , DE 199	973	
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused th	e death. Do not	enter the mode of dying, such	as cardiac or re	espiratory arrest	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Aci	\odot	NAC FAILUR	Ē			Onset and Death
/Medical Examiner		resulting in death)	-	consequence of):	1				23 =2400
		Sequentially list conditions, if any, leading to immediate		HYDRAT	ION				2 WELLS
uted	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	ANO	rrem A					4 WEEKS
be executed sicien and burial-transit		resulting in death) Last	Due to (or as a c	consequence of):					
ta yat	Medical		d SYSTEM	ne Ill	ness suspec	TED BU	TOW P	PROVEN	3 MONTHS
n certific anding p use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	livery
The law requires that the death ce ite has been signed by the ettendi page 2 should be detached for use	Fnysician	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live birth 2 4☐Pregnant at tin 9☐Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
res that igned b	2	Part II. Other significant conditions of	_		underlying cause given in P	art I.	23e. Did toba	cco use contribute t	to the cause of death?
w require been sig should b	ied i	CORONARY ARTER	y Biseas	t			1 ☐ Yes	2, ⊠ No 3 □ P	robably 4 Unknown
law r les be s 2 sh	Completed	KECENT PNEUM	MINIA				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	5						performe	d? death? 5No 1 ☐ Ye	
ysicien: lis certifice director, p	ן ם	25. Was case referred to medicat examiner?	Hospital:		0***	lace of Death (C			
ding Phys h. After this funeral di	0	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpa 28b. Time	of 28c. Injury at		5 Resident d. Describe how	ce 6 Other (Spa	ecify)
Attending Physicien: r death. ector: Atter this certific by the funeral director.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(e <i>ar</i>) Injur	y Work? M 1 ☐ Yes 2	2 □ No			
al or Atter de la Directo	Certification;	3 Suicide 6 Could not be determined		r - At home, farm, (Specify)	street, factory, office	28f	Location (Stree City or Town,		Bural Route Number,
	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of on the basis of example and manner state	xamination and/o	eath occurred at the time, date r investigation, in my opinion,	e and place, and death occurred	d due to the cau at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To th withir To th comp		29b. Signature and title of certifier			29c. License numb	oer .	290	d. Date signed (Mor	th, Day, Year)
		Iterous.	MD		D 33700)	4	my 21,	2008
10 M		30. Name and address of person who	completed cause of dea	th (Item 23a) (Ty	pe, Print)	0	27. MI	> 217	GE
State		JED E. Howe. MD 31. Date filed (Month, Day, Year)		Signature_	WST. WILLIA	ams per	et, mi	ا کا کا	73
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Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ju1y 09:52 PM 21 2008 Eloise Catherine Tiller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 North Washington Street North East Cecil if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 X F 218-26-3996 July 29,1927 80 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified ** once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXYes 2 □ No Director Maryland Ceci1 North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 6 North Washington Street United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Toll Collector Highway 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Hyland Clarence Fitts 2 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) North East, Maryland 21901 Laws W. Tiller / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition $J_{2008}^{1208}^{28}$, XBurial 2 ☐ Cremation 3 ☐ Removal from State Old Bohemia Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Crouch Funeral Home Signature of Fund Sovice Insee 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovanion Cancer UNKNOWN Physician Metastour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Dav Year 5 ☐ Other (specify) signed by the a t be detached f 9 Hilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by we zily 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitai: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) or Attending 1 Natural injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital 29a. Certifier 1 V certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -22-08 D0026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. North EAST, Md 21901 Madhu Sachder, M.D. E. Cecil 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

08-05465 **Eugene Tillery** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

26 25		1- For State Registrar	otato or maryiqila	••	te of Dea	th		Reg		108 25	22
Physicia dical Exami	an/	1. Decedent's Name (First, M Eugene	nddle,Last)	ery				2. Date of Death Month D July 16, 200		3. Time of Death 0000 hrs	1
All way		4a. Facility Name (if not instit 2410 Brightseat Ro	-)	Hya	Town, or Location			4c. County of Prince Ge	orge's	
Funeral Director		5. Social Security Number 579–06–1708	6. Sex 7. A	ge (In yrs. last birtho 28	day) If Un Mont		urs Min.	8. Date of Birth		9. Birthplace (State or Foreign Wash., Country)	D.C.
ow any		Usual Residence of Deceder 10a. State 10b. Cou Maryland Prir	nt	10c. City, Town or		-1				10d. Inside City	
th the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 12251 Fletche] 20,12		p Code 20720		10g	. Citizen of Wha	t Country?	
death with the or items 23a must be noti	Funeral L	11. Marital Status 1 X Never Married 2	Married 12. Was Deceder Armed Forces 1 X Yes 2	3?	If Yes, spec	tent of Hispanic (cify Cuban, Mexic			14. Race - White,	American Indian, Black etc. Black	ζ,
imore, MD 21215-0036 pees 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene. ant: If iten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by		Divorced If Yes, Give Year Of Or Dates: Specify only highest grade co	ompleted) 16a. D	ecedent's Usua uring most of w	al Occupation (Girorking life, DO N	ve kind of w OT use retir		Specify:		
b, MD 21215-0036 and 2 should be filed within 72 lealth and Mental Hyglene. Item 27 is marked other than traumatic event, the Medical	Completed	12 17. Father's Name (First, Mic Curtis Til		M	letro Bi	as Opera	her's Name	(First, Middle, Ma a Brown	Metro		
MD 21215-003 d 2 should be filed within the and Mental Hygiene. In 27 is marked other thumatic event, the Med	To Be	19a. Informant's Name/Relat	tionship (Type, Print)	19b. 12	Mailing Addre	Street and Netcherto	Number or R WN Rd	Rural Route Numb	er, City or 78%. MD 207	State, Zip Code)	
Baltimore, MC bermit. Pages 1 and 2 s Department of Health at Important: If item 27		20a. Method of Disposition 1 X Burial 2 Cremi 4 Donaţion 5 Othe	ation 3 Removal from S	cremato	ry or other place	Jets. Ce	m 7/2	2/2008	Crownsv	City or Town, State	
Baltimo permit. Page Department of Important: injury or off		21. Sign of Funeral Ser	vice Licengee		9013	Annapol	is Rd	. Lanhan	n, MD 20	706	į,
Physician /Medical xaminer		23a: Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise or condition resulting in deal	ease a. Dilated	cardiomy			is cardiac o	r respiratory arres	st, shock, or hear	t Approximate I Between Ons Death	set and
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760, icate be executed physician and the burial - transit	Medical	X UNPENDED IF FEMALE:		a,27,perM	E, g882	8/7/08	TT		23d. Date of o	teliven	
characteristics box 6876 that the death certifical ned by the attending phetached for use as the	hysician/N	23b. Was decedent pregnant past 12 months?	t in the 1 Live birth 4 Pregnant	at time of death 5	Fetal dea		opic pregna	incy	Month	•	ear
P.O. B es that the d igned by the	by P	Part II. Other significant co	onditions contributing to dea	ath but not resulting	in the underly	ng cause given ir	n Part I.			Probably 4 V Unk	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	ompleted							24a. Was a autops perform	y pr ned? de	Vere autopsy findings arrior to completion of causeath? Yes 2	
Vital Rec ysician: The l his certificate l	Be C	25. Was case referred to me examiner?				26.Place of De		only one)			
f Vit Physic er this c	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		itpatient 3	DOA Other			Residence 6 v		
on of value Physics ath.	tion:	1 X Natural 5	Pending (Month, Day	y,Year)	inic of rigury	1 Yes 2		Edd. Describe II	ow injury cocurre	•	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6	Investigation Could not be determined 28e. Place of (Specify)	Injury - At home, fa	rm, street, facto	pry, office building	g, etc.	28f. Location (S or Town, St		er or Rural Route Numb	er, City
DIV To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (ng Physician: To the best of Examiner:On the basis of ex	kamination and/or in							
To To our	Mec	29b. Signature and title of co	and manner state ertifier	d		O.C.M.E.			29d. Date signe	ed (Month, Day,Year)	
Je	21.00	30. Name and address of per Laron Locke MD.	erson who completed cause o Assistant Medical E		Penn Stre	et, Baltimore	, MD 212	201	-11	-	
S Regis	tate	11 11 2 1 7110	(ear) 32. Regist	trar's Signature							

ORIGINAL

			For State Registrar	State of Ma	•	artment of Health and rtificate of Death		ene 008	25228
ı	Physici /Medic		1. Decedent's Name <i>(First, Middle, La</i>	st) NDA JANE VA	AUGHT		2. Date of Deat Month JULY	Day 2008	3. Time of Death 10:10 PM
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location of D	eath	4c. County of Death	
			HARFORD MEMORIA			HAVRE DE		HARFORD	
	Funeral Director			Sex 7. Ag I□M 2XDF	e (In yrs. last birthday) 64 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	Ain. 8. Date of Birth (Month, Day,	1943 MAR	place (State or Foreign htry) YLAND
	/land		10a. State 10b. County		10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Man P-f et	tor	MARYLAND HAI	RFORD		HAVRE DE G	RACE		1 XYes 2 ☐ No
	with the	Dire	10e. Street and Number 515 WARREN ST		9	10f. Zip Code 21 078	10	og. Citizen of What Cour USA	ntry?
21215-0036	72 hours after death with the Maryland naturel; or tteme 23a or 28a-f ehow digal Ezamirar mizat be notitied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:	Ever in U.S. 13. No	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 🌠 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
5-0	be filed within 72 hc tal Hygiene. d other then "natur event, ir e Mudical	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/In	dustry
121	within ene. then	ם	Elementary/Secondary (0-12)	College (1-4ar 5	i+)	DO NOT use retired) WAITRESS		RESTAURA	ידיוא
	filed Hygie Hygie other i		17. Father's Name (First, Middle, Last)			Name (First, Middle, M		71.1
land		To Be	JOHN RHOADES C				DALTON		
Mary	should and Men le marke eumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number of	r Rural Route Number,	City or Town, State, Zip	Code)
	alth a		SHANNON L. WILSON	N / DAUGHT	ER 145 E	BLOOMSBURY AVENU	JE, HAVRE D	E GRACE, MI	21078
Baltimore,	8 ° ± 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		20b. Place of Dispo cemetery, cren BERKLEY	natory or other place)		DARLINGTON	
Balti	permit. Par Departmen Important: any njury		21. Signature of Funeral Service Lice			. Name and Address of Facility LISA SCOTT F	TUNERAL HOM	Œ, P.A.	MADY AND
	_		23a. Part1. Enter the disease, or comshock, or heart faifure. List only	plications that caused	the death. Do not ent	552 LEWTS ST er the mode of dying, such as care			Approximate
	Pnysician /Medical Examiner		snock, or near failure. List only Immediate Cause (Final disease or condition resulting in death)	ue to (or s	a cons-cuente of):	ow Encer	Halopa	thy	Interval Between eath
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence(o():	acaeaa y	yacci	B A	S.Mu
	ificate be executed g physicien and as the burial-transit	Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Mrs		tructive ?	ulmonary	Lisease	Jeary
00	e exe cien a urial-t		resulting in death) Last	Due to for as	a consequence of	2	\		1
68760	cate b	edicai		q. 1 2000	co ca	ruse			•
O. Box 6	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Ho 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ds, P	uires thet signed b	ρ	Part other significant conditions of	contibuting to death b	ut yot resulting in the us	nderlying cause given in Part I.	23e. Did tob	eacco use contribute to the	
Il Records		Completed	abdominal	arti	c Onew	rysm Stent	24a. Was at autops perform	y prior to co	psy findings available mpletion of cause of
Vital	Iclan: T certificat ector, pa	Be	25. Was case referred to medical examiner?	Hospital: 🗸		1	Death Check only on	9)	
of	Phys this af dir	은	1 Yes 2 No 27. Manner of Death	28a. ate of njur	nt 2 ER/Outpatien			nce 6 Other (Specif	y)
	ding h. After funer	ţ	1 Natural 5 Pending	(Month, Day	Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division	r Attending ter death. Irector: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not b		ury - At home, farm, str		28f. Location (St.	reet and Number or Rura	al Route Number.
á	7 2 2 2	Certification;	4 Homicide determined	building, etc	: (Specify)	,,	City or Town	, State)	
	To the Hospitat or within 24 hours effer To the Funerel Dir completely filled in	edical (29a. Certifier (Check only one) Certifying Ph	nysician: To the best of miner: On the basis of and manner sta	examination and/or inv	occurred at the time, date and placestigation, in my opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner as s ate and place, and due to	tated. the cause(s)
	To th withir To th comp	Ň	29b. Signature and title of certifier	Bruch	J.M.S	29c. License number D00 369	40	od. Date signed (Month, puly 20	2008
72-1			30. Name and address of person who	completed cause of d	ea to (Lem 23a) (Type,	AVENUE . HA	WRE DE	CRACE	21878
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 3 2008	32. Registra	ar's Signature	AVENUE, H			

DHMH 17 Rev 1/2001

08-05206 Gregory Weidman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25229

ory vveidina		1- For State	010	ate of Maryi	C (Certifica	ate of	Death				R	leg. No.				
Physicia		Registrar 1. Decedent's Name (F	irst, Middle	e,Last)								Date of Dea Month	Dav	Year		Time of Dea	
ical Exami		Gregory W			n							July 6, 20		Country of	Dooth	13331113	·
		4a. Facility Name (if no	ot institutio	n, give street and n	umber)		41	b. City, Tov		cation of	Death		1	County of			
		12817 Baker I	Dr.					Silver S				(=		•		olace (State	DF.
Funeral		5. Social Security Nun	nber	6. Sex	7. Age (In y	rs. last birt	hday)	If Under	_	If Under Hours	24Hrs. Min.				Foreign	Washi	ngton
Director		577-34-51	76	1X M 2 F		81	Yrs.	Months	Days	Hours	IVIII.	2/15	/192	27	Coun	trý) <u>D</u>	.Č.
		Usual Residence of D														0d. Inside C	its Limite
апу			b. County		10c.	City, Town	or Location	on									
						Silv	er S	pring							1		2 X No
land f sh	to	MD M 10e. Street and Numb	lontgo	omery		DII	<u> </u>	10f. Zip C					10g. Citi	zen of Wh	at Count	y?	
Mary 28a	Director								200	904		İ		U.	S.A.		
with the Maryland ms 23a or 28a-f show be notified at once.		12817 Bak	er Di	rive		:- 11.0	142 10/2	c Decedent			in? (Spe	cify Yes or N	NO-			an Indian, Bl	ack,
ms 2	Funeral	11. Marital Status 1 X Never Married	2 🗆 🖪	Married Armed	ecedent Ever Forces?		If Y	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)		White	e, etc.		
death or ite	ı,			1 Yes	2 X	No	1	Yes 2	No	enecify:				Specify:	Whit	e	
after al", o	by F	3 Widowed		vorced If Yes, Give Y		1 160	Deceden	t'e Heual O	ccupatio	n (Give l	ind of wo	ork done	16b.	Kind of Bu			
ours atur x mi	듛	15. Decedent's Edu				ed) 16a.	during m	ost of work	ing life.	DO NOT	use retire	ed)					
72 h	Completed	Elementary/Secon	dary (0-12)) College	(1-4 or 5+)		D	4					М	erk1	Pre	ess	
5-UU30 iled within 7 Hygiene. I other than	ᄐ	12					Prin	ter	- 11	8 Mother	s Name	(First, Middle					
tygic of the left w	ြပ	17. Father's Name (F							- 1								
LILI ould be fil Mental I marked ic event,	a	Charles	J. We	eidman		T46	Oh Moilin	a Address	(Street	Bess	ber or R	(U <u>nkno</u> Jural Route N	lumber, (City or Tov	vn, State,	Zip Code)	
ould d Me	P	19a. Informant's Nan				1"											D 20.
MD d 2 sho lith and m 27 is		Carlton	Green	n, Lawyer		20b. Place	7309	Balt Balt	e of cen	re Av	<u>renue</u>	Date	200	. Location	- City or	ark, M Town, State	<u> </u>
e, land Heal Heal		20a. Method of Disposition 1 X Burial 2	osition Crematic	on 3 Remova		crema	atory or of	ther place) s Cat	hol:	i o							
Baltimore, MD 21215-UU30 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygievite Importanti. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Ex miner must be notified at once.		4 Donation 5				St. M	Ceme	terv			7/:	24/200	8 Wa	shin	gton	, D.C.	
it. P urtme ortar ry or		21. Signature of Fun	eral Service	ce Licensee				Name and								imore	
Depression of the property of	1	10	1)	· U I	Lan	rina	Ga	sch's	Fu	nera	L Hor	me, P.	A. I	lyatt	svil	le, MD	2078 ate Interva
Physician	-	23a. Part I. Enter the	e disease,	or complications the	at caused the	deadbo	not enter	the mode o	f dying,	such as	ardiac o	r respiratory	arrest, s	hock, or h	eart	Between	Onset and
"Medica		failure. List only	y one caus	se on each line.												De	eath
amine		Immediate Cause (F or condition resulting	Final disea: q in death)		as a conseque												
	H			h.												<u> </u>	
	à	Sequentially list cor if any, leading to im	nditions, mediate	Due to (or a	as a conseque	ence of):											
	Evaminor	cause. Enter Unde (Disease or injury the	rlying Caus						_	_							
_ :=	. }	events resulting in	death) Las	bt Due to (or	as a consequ	ence ot):											
ecuted and - transit	1 -			d													
e exe cian a		UNPENDED		AMEND	ED								- 1	23d. Date	of deliver	1	
Ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed r death. rector: After this certificate has been signed by the attending physician and rector: After this certificate has been signed by the attending physician and	Medical	IF FEMALE:	nont is	- 41- 0	es, outcome	of pregnan			3	Ectop	ic pregn	ancv	- 1	Month		y Day	Year
Box 687 e death certific the attending p	8	23b. Was decedent past 12 months	pregnant ii ?		ive birth regnant at tim	ne of death		=etal death Other (Sp∈			no prog	,	- 1				
ath ca	60 1	7 1 Yes 2	No g		Inknown		5 (Other (Spe	chy)								
ge ge	3	Part II. Other signi			ng to death b	ut not resul	Iting in the	e underlyin	g cause	given in I	Part I.					the cause of	of death?
P.O.	Letaci	L Part II. Other sign	nicani con	Iditions continue	ing to count		•					1	Yes 2	2 V No	3 Pro	obably 4	Unknowr
ires that	2											24a. \	Was an	241	b. Were a	utopsy findir	ngs availat
requer been	pinous												autopsy performe	d?	prior to death?	completion	of cause o
e law	2	Completed												No	1 🗸 `		No
Real The	g.		red to med	dical					26.Plac	e of Dea	h (Check	k only one)					
vision of Vital Rec or Attending Physician: The I after death. Director: After this certificate I	ecto	examiner?		Hospital: 1	Inpatient	2 EF	R/Outpatie	ent 3	DOA	Other ₄	Nurs	ing Home	5 Re	sidence (6 🗸 Oth	er: Scene	
of Vit ing Physic After this	ᇙ	O 1 ✓ Yes 27. Manner of Dea	2 No	28a.	Date of Injury		8b. Time	of Injury	28c. In	jury at Wo	ork?	28d. Desc	cribe how	injury occ	curred		
Affe	E L	1 Natural		Pending (Month, Day,Yea	ır)			1_	Yes 2	No	1 .					
Division of Vital Records, tal or Attending Physician: The law requiring after death. The process of the proce	ag	1 Natural 2 Accident 3 Suicide 4 Homicide			Place of Inju	n. At hom	o farm s	treet factor	v office	building.	etc.	28f. Locat	tion (Stre	et and Nu	mber or l	Rural Route	Number, C
Vis or Al	E	3 Suicide		Could not be		ry - At noni	e, laiii, s	tieet, lactor	y, omoc	, , , , , , , , , , , , , , , , , , , ,		or To	wn, Stat	e)			
pital Direction	Elled	4 Homicide			ecify)	_						- d due to the) and mar	ner as st	ated	
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct	tely	1 29a Centiler.	Certifyin	ig Physician: To the	e best of my	knowledge	, death oc	curred at the	ne time,	date and	occurred	nd due to the d at the time.	, date an	d place, ar	nd due to	the cause(s)
thin the	ldu	(Check only one) 2 2	Medical	Examiner: On the to and mar	ner stated.	ination and	/or invest							Od Date	signed //	Month, Day, Y	'ear)
	8	29b. Signature an	d title of ce	ertifier				2		nse numb	er					, 2aj, i	,
		D. W	wil)	- 1 MD					0.0	C.M.E.			,	July 7, 2	2000		
10		20 Name and ad-	drees of no	erson who complete	d cause of de	ath (Item 2	3a)		100								
CA	İ	Donna M.			ant Medica	al Exami	ner 1	111 Penr	n Stree	et, Balt	more,	MD 2120	1				
.>/		0.4 (D00.00) p.40(4)	-		32. Registrar												
	Sta		3" 200	8"	B	do	de										
Reg	jist	al.		A STATE OF THE PARTY OF THE PAR		1.66											
		01	•	COME			ORIGI	NAL									

			1- For State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death	Mental Hygien	<u>2008 25230</u>
		н	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Joseph August Woolcock		July 1	ay, 2008 8:00 aм
į	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			9200 Weathervane Place 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Montgomery Vil	Lage 8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
	Funeral Director		111-38-9440 11⊠ M 2□ F 75 Yrs.	Months Days Hours Min.	Month, Day, Yea Dec. 06, 1	r) Country)
			Usual Residence of Decedent			
	arylar show	<u>-</u>	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f notifie	ecto	Florida Dade Miami 10e. Street and Number	10f. Zip Code	10g C	Citizen of What Country?
	3a or	Ö	488 NW 165th St. Road; Apt. B-109	33169	l sign -	United States
	death ms 2: r mus	Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
õ	or ite		1 □ Never Married 2 1 Married 1 □ Yes 2 1 No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	o raidan, etc.)	Specific
2-003p	hours tural", al Exa	od by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	16h	Black Kind of Business/Industry
<u>.</u>	in 72 n "na"	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	king	,
7 7	d with giene er tha	Com		ort Export Trader	In	nport / Export
and	be file tal Hy d othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide	en Surname)
<u>X</u>	ould a	٤	Augustus Woolcock	Unknow		
Ma	d2sh thanc 7ism traum			ing Address <i>(Street and Number or Ru</i> W 165th St. Rd.;		
<u>ရာ</u>	tem 2		20a Method of Disposition 20b. Place of Disp	osition (Name of		Location - City or Town, State
Baltimol	Pages ent of nt: If i		1 Burial 2 Notemation 3 Hemoval from State	oln Crematory 7/22	2/2008 Br	entwood, MD
<u>=</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Department of Heath and Mentall Hygiene. Important: If lem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			22. Name and Address of Facility mple Tribute Fune		
מ	8 2 E 8			<u>040 Rockville Pike</u>	e, Rockvill	e, MD 20852
			23a. Part1. Ento the diseaso or complications that caused the death. Do not en shock, or hart failure, ist only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Caus (Final disease or continuous a. Cancer of Unknown resulting in death)	primary		
	Examiner		Due to (or as a consequence of):			
	9 M.	Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury) Due to (or as a consequence of):			
	cuted nd ransit	Examiner	that initiated events C.			
Ď,	icate be executed physician and s the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):			
04/80	icate b physic the b	dical	d			
POX P	the death certificate y the attending phys ched for use as the	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
ĕ	death e atte	iciai	in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)		Month Day Year
j S	at the by the	hys	9 ☐ Unknown			
Š,	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2□ No 3□ Probably 4☒Unknown
coras	requi	eted				
rin .	has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VItal	in: TI iificate or, pa	ပိ	25. Was case referred to medical	26 Place of Dea	th (Check only one)	No 1 ☐ Yes 2 ☐ No
>	yslcia is cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	I a .		6 KlOther (Specify)Son's Home
ם ב	ng Ph fter th neral		27. Manner of Death 1 № Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how in	
VISION	tendineath.	catic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
<u> </u>	or At fter d Direc in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	281. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The I within 24 hours free death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	edical Ce	29a. Certifier 1 ★ Certifying Physician: To the best of my knowledge, dea (Check of my knowledge) 2 ★ Medical Examiner: On the basis of examination and/or			
	o the ithin 2 o the ompler	Med	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	10		Devenere (No Cles St. m.)	D0064615		July 15, 2008
•	4	- 9	30. Iame and address of person who completed cause of death (Item 23a) (Type			541y 13, 2000
		1. 7	Genevieve Wroblewski, M.D. 1355 P	ccard Dr. #100, R	ockville,	MD 20850
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	acti)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25231

Alexander Monday		eisser - For State	S	tate of N	Maryland	/ Depar	tment ficate	of Hea	ilth and Ment <i>th</i>	tal Hygi		, No	200	18 2	2523
Physician	R	egistrar . Decedent's Name	e (First, Midd	dle,Last)		00717		0, 200			Date of Death		Year	3. Time of D	
Medical Examine	er	ALEXAI	NDER	MOM	NDAY	WEISS	ER			Jı	Month uly 10, 20			2351 hi	rs
*	4	ta. Facility Name (i Middlebrook				')			Town, or Location of mantown	of Death	12-		unty of Death itgomery		
Funeral	٩,	5. Social Security N		6. Sex		ge (In yrs. las	t birthda			er 24Hrs. 8.	. Date of Birtl	n(MM/DD/	YYYY) g. Bir	thplace (State	e or
Funeral Director		218 [±] 31−3	485	1 X M		33		Yrs. Mon	ths Days Hours	Min.	July	28,	1974 ^{Co}	untry) M	ID
any		Usual Residence o 10a. State	10b. County	/		10c. City, T	own or L	ocation						10d. Inside	· ·
	_	MD	Mon	tgome	ery		G	erman	ntown					1 X Yes	2 No
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu 13613		kwood	l Lane				20874			U	of What Cou		
tems 23.	Funeral	11. Marital Status 1 Never Marri	ed 2		. Was Deceder Armed Forces	s?	5. 13	3. Was Dece If Yes, spe	dent of Hispanic Ori cify Cuban, Mexican	gin? (Speci n, Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Amer White, etc.	rican Indian, E	3lack,
		3 Widowed		ivorced of Ye	Yes es, Give Year	2 X No			2 X No specify.					hite	
ours af	g o	15. Decedent's E	ducation (Sp				16a. Dec	cedent's Usu	al Occupation (Give vorking life. DO NOT	kind of work use retired	k done)	16b. Kind	of Business/	/Industry	
6 n 72 h	Completed	Elementary/Sec		2)	College (1-4 o	r 5+)		-	rpenter			C	onstr	uctio	$_{\rm n}$
-003 I withi giene. ther the	틹	17. Father's Name	Lth (First, Midd	le, Last)							irst, Middle, f				
215. De filed ntal Hy rked of	Be	Walt	er W	eisse					L	ucy P	Araya			7: 6 4:	
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 X Burial 2	Cremat		Removal from			or other place ck M∈		7/17	7/08	0	lney,	MD	
altin mit. P partme portar	ŀ	4 Donation 9	uneral Servi	ce Licens		Den	1		and Address of Facili						
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Physician / /Medical		failure. List of	the disease; nly one cau	se on each I	ine.		DO HOU	sinter the mod	ac or dying, saon de						n Onset and Death
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Box 6876 e death certificate the attending phy ed for use is the b	Physician/M	past 12 mont				t at time of de		Other (
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Division of Vital Records, tal or attending Physician: The law requirt is after death. "I Director: After this certificate has been siled in by the fumeral director, page 2 should t	tion: 1	27. Manner of De	5 🔲 F	Pending	28a. Date of Jul 10, 200	Injury av Year) 08	28b. Ti 2350	ime of Injury hrs	28c. Injury at We	✓ No a	Subject me accident	otorcycli	ist involve	d in motor	
Divisical or Atters and or Atters a select design by the	Certification;	2 🗸 Accident 3 Suicide	6 🗌 (nvestigation Could not be determined		of Injury - At h		m, street, fac	ctory, office building,		or Town	Ctntn)			Number, City mantown, Mi
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use is the b	cal Ce	4 Homicide 29a. Certifier (Check only one)	9		To the boot o	of my knowles	dae desi	th occurred a	at the time, date and in my opinion, death	place, and o	due to the ca	use(s) and te and plac	manner as s	stated. the cause(s)
To the within To the comp	Medical	29b. Signature a		a	nd manner stat	ted.			29c. License numb	per				Month, Day, Y	
2	_	The	den	W1	King	This	w)	O.C.M.E.	OCA	ME	July	11, 2008		
		30. Name and ad Theodore				of death (Iter it Medical		ner 111	1 Penn Street, I	Baltimore	e, MD 212	01			
	tate	31, Date filed (M				istrar's Signa		Coast	,			<u> </u>			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** $A^{\ \mathsf{M}}$ 17 2008 4:43 John July Williams, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 11–20–1924 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Wash., D.C. 83 219-16-1093 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 Deale Road 20751 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 17 Yes 2 No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) baker bakery shop owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams. Josephine Catherine Giovannini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Mae Williams, 620 Deale Road, Deale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) So. Memorial Gardens 07-21-08 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Onknown le tastasi 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has page 2 s autopsy perform certificate hrombou topenia To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Division 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 25250900 ガルノカ

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 1 2008

2001 Medical Parkway

<u> Annapolis, MD 21401</u>

and address of person who completed cause of death (Item 2 a) (Type, Print)

+AMLETTE, M.D

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month July 20, 2008 Year Roger L. Werner 130 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2550 Finzel Road **Finzel** Garrett If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 215-42-4985 1**∭**M 2□F Min 66 October 17, 1941 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland Garrett **Finzel** 1 ☐ Yes 2 No Director 2550 Finzel Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces:
1 DYes 2 □ No
1 Yes, 3 □ No
1 Yes, 3 □ No
1 Yes, 3 □ No
1 Yes, 6 □ No
1 Hes. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Laundry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be Joseph E Werner Velma A Mckenzie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1256 West Finzel Road Frostburg Maryland 21532-19a. Informant's Name/Relationship (Type. Print) Victor Werner brother Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State remetery, crematory or other place)
Finzel Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State July 24, 2008 Finzel Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 21. Signature of Funeral Service License art1. Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Oronary Ordas /Medical Due to (or as a consequence f): **Examiner** Sequentially list conditions, any sea ingle immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ası ed by the attending | detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No A ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 2+ and address of person who co use of death nes 600495 31. Date filed (Month, Day, Year) State JUL 2 2 2008 Registrar

Please Type

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tate of Maryland / Department of Health and Mental Hygiene 2008	25234
Cortificate of Dooth	

		•	State Registrer		Olato (, , , , , , , , , , , , , , , , , , ,	(Certifica	ate of		morna	Reg. No		20204
			1. Decedent's Name	(First, Middle, Las	st)						2. Date of D			3. Time of Death
	Physicia /Medic	al		DELMA WEI		umbar)		45 6:	. T	- Location of Do	July	T .	2008	1 0:15a M
	Examin	er	4a. Facility Name (If			imber)		45. Cit		r Location of De	atn	40.	. County of Deatl	
			1603 M 5. Social Security Nu	ain Stre		7 Age (In)	yrs. last birth	day) If Und	Card der 1 Year	liff If Under 24 Hi	rs. 8. Date of 8	lidh	Harfor	nplace (State or Foreign
	Funeral Director		218-14-1 Usual Residence of I	509	_М 2 ∑ Т		85 Yr	Month		Hours Mi		/1922	Mai	ryland
	and **		10a. State	10b. County		10c.	. City, Town	or Location						10d. Inside City Limits
	daryl f ehc	ö	MD	Harfor	Б		Car	diff						1 Yes 2 No
	the 28a-	Director	10e. Street and Num						Zip Code			10g Cit	tizen of What Co	untry?
	th with 23a or	ai Di		in Stree	t					160			nited St	•
	r dez	Funeral	11. Marital Status		12. Was Dec Armed F	cedent Ever i	in U.S.	13. Was Dec	cedent of F	Hispanic Origin? an, Mexican, Pu	(Specify Yes or It erto Rican, etc.)	NO-	14. Race - Ame Black, White	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow the Madical Exeminan maal be modified at	by	1 ☐ Never Marrie		1 □ Yes If Yes, G Year or I	2 No live Dates:		1 🗆 Yes	2 X No	Specify:			Specify: V	hite
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<u>a</u>	should bund Ment	2	Charles	Francis	Wineke)				Edith	Elizabe	eth B	rieghner	•
a	2 shc and ie m		19a. Informant's Na	me/Relationship (Type, Print)		19b. I	Mailing Addre	ess (Street	and Number or	Rural Route Num	ber, City	or Town, State, 2	(ip Code)
e,	of Health of Health item 27 other tr		Andrew 20a. Method of Disp	F. Welch	, Jr./S	Son 20	b. Place of D	Disposition (A	Vame of		rdiff, M		21160 ocation - City or	Town, State
E E	0 0		1 🗆 Burial 2 🖸	Cremation 3 ☐ 5 ☐ Other (Specif	Removal from	State	cemetery,	crematory o	or other pla	atory 7/	13/08		ola, PA	,
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Fur	neral Service Lice	see	1	1	22. Name	and Addre	ess of Facility	600 N	lain	Street	
	90 E # 9		4-2/1	my!	Xor	rlu	Se						elta, PA	
_			23a. Part1. Enter the shock, or hear		dieations that one cause on	caused the cleach line.	deth. Do no	t enter the m	node of dyli	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (I disease or condition resulting in death)	Final	a. Y \	yoca	rdia	1 IV	1tor	ction				24 hars
7	/Medical Examiner		resulting in deality	(Due to	(or as a con	sequence of): (1					Human
-1		16	Sequentially list con	ditions	b. Due to	(or as a con	U TO	uiure	_					- Jua
	ted nsit	nju	if any, leading to im- cause. Enter Under Cause (Disease or i	tying	000 10	7 (01 83 8 0011	is a since of	<i>y</i> -						0
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××	certific nding p		IF FEMALE:		23c. If yes, or	utcome of pro	000 0004							
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$\mathcal{O}_{\mathbf{g}}$	s that the de ned by the e detached f	by Ph	Part II. Other signifi	cant conditions	contributing to	death but not	t resulting in	the underlyin	g cause gr	ven in Part I.	23e. Di	d tobacco	use contribute lo	the cause of death?
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Division of Vital Records, P.	4 5 CA	Completed		·							pe	topsy rformed?	prior to death?	llopsy findings available completion of cause of
西村	in: T	Ö	25. Was case referr	ed to medical						26 Place of C	1 Yes	2 2 No	0 1 ☐ Yes	2 No
5	Physician: rthis certific ral director,	0 8	examiner? 1 ☐ Yes 2 🛂		Hospital:	Inpatient	2 ER/Out	natient 3	DOA Ott				6 □Other (Spe	cufu)
o	g Phy er thi	n: T	27. Manner of Death	1	and the second	e of Injury onth, Day Yea		me of	28c. Inju Wo		28d. Describ			chy)
Ö	Attending r death. ector: Afte by the fune	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigatio		mii, Day 19a	D/ In	ury M		Yes 2 No				
Divis	l or Atte efter de Directo d in by th	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 Could not b determined	289. Plac	ce of Injury - A	At home, farr	n, street, fact	tory, office			(Street a. Town, Stat		ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	1 Certifying Pl	niner: On the	basis of exar	knowledge, mination and	death occum	ed at the ti	me, date and pla opinion, death or	ace, and due to the	ne cause(s e, date an	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	and ma	nner stated.			29c. Licen:	se number		29d. Da	ate signed (Mont	h. Dav. Year)
	⊬≱⊬g) Ma	us Ber	adefle	No	ntelle	om.t) DC	00560x	91	0	7/11/20	20
-			30. Name and addre	ess of person who	completed car	use of death	(Item 23a) (1	ype, Print)	-		-1		, ., .,	- 8
				Martell	o, M.D.	., 262	3 Whit	eford	Road	, White	ford MD	21160)	
	Sta Registi	ate	31. Date filed (Mont		200832.	Registrar's S	Signature	Los	ارمي					
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DY DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 07 Ray Welch 26 2008 10:37 A Ernest /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Garrett Co. Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F Director 218-30-0233 02/27/1936 Hutton, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show "natural", or Items 23a or 28a-f sho 1 Yes 2 No Director MD Garrett Mountain Lake Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 197 Oak Street 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X2 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than 5th Trucking Truck Driver permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygid Important; If Item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Roy Welch Margaret Nelle Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Y. Welch/ Wife 197 Oak Street, Mountain Lake Park, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Na Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Mem. Gard. 7/29/2008 | Oakland, Maryland 22. Name and Address of Facility Stewart Funeral Home 21. Signature Funeral Sivice Lic and 32 South Second Street, Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic cardiovascular disease 8 yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o Completed by 1X Yes 2 No 3 Probably 4 Unknown chronic obstructive pulmonary disease Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 certificate has 1∐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours a

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

07-27-2008

D30035 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550

State Registrar

completely

Medical

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31. Date filed (Month, Day, Year) 2008



			For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmei <i>rtifica</i>	nt of He te of D	ealth a <i>eath</i>	and M	ental Hyو ا	giene, Reg. No.	2008	3 25	5236
B	Discolate		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath Day	Yea		e of Death
	Physicia /Medic		Thomas	Richa	rd	Wat	son				July 3	30, 2	2008	5:4	+2 A M
	Examin	er	4a. Facility Name (If not institution		ımber)		1	, Town, or L					County of De		
# 10 m	×		Memorial Hospit 5. Social Security Number		7 4 //-	a una lant hinthala.		Cumber er 1 Year	Land If Under		8. Date of Birt		llega		t
	Funeral Director		218-40-3181	6. Sex 1 X M 2 ☐ F		n yrs. last birthday 6 Yrs.	Months		Hours	Min.	(Month. Da	, _{Year)} 8 19		irthplace (Sta Country) arylanc	_
	and		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or L	ocation							10d. Inside	e City Limits
	Maryl f sho	jo	MD. Alle	jany		Weste	rnpor	t						132	′es 2 □ No
	with the a or 28a be notif	Direc	10e. Street and Number 421 Hammond St	. Apt.	307		10f. Z	p Code 21562	•			-	ted St		
	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dec Armed F	cedent Eve	r in U.S. 13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)			nerican Indiar	9
0036	ours afte ral", or it Examin	þ	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	ed 1 Tyes If Yes, G Year or I			1 ☐ Yes	2 X No	Specify:				Specify: V	hite	
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land	should be filed within and Mental Hygiene. smarked other than "sumatic event, the Meraumatic event, e	To Be (17. Father's Name (First, Middle, Robert Wa	_{Last)} itson SR						er's Name ixie	(First, Middle, Paug		Surname)		
Mary	and 2 should be ealth and Mental n 27 is marked er traumatic ev		19a. Informant's Name/Relations Delores Simon/	nip (Type. Print) sister	-						i Route Numbe iedmont				26750
nore,	_ 7 5 5		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	20b. Place of Disp cemetery, cro Kalbaugh	osition (Na ematory or Ceme	ame of otherplace)	08/0 2008	2/	20c. Loc Elk	cation - City Garder	or Town, State)
Баппро	permit. Pages Department of I Important: If Ite any injury or ot		21. Signature of Funeral Service		2	2	22. Name a	and Address	of Facilit	by Boa	al Fune ternpor	ral :	Home arvlar	nd 2156	2
%			23a. Part1. Enter the disease or shock, or heart failure. List	complications that only one cause on	caused the								ar y zar.	Approxi Interval	mate Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Se	PSI:	onsequence of):								days	nd Death
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8/60	ficate be executed physician and s the burial-transit	dical E		d											
POX P	h certific anding p use as	in/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or			□ Estania.					2	23d. Date of	delivery	
р Э	the deat y the att iched for	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at tim		□Ectopic □ Other (s						Month	Day	Year
ds, r	ician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	ns contributing to	death but n	ot resulting in the	underlying	cause giver	n in Part I.		23e. Did to		/	to the cause	of death? □Unknown
Records	law req as beer 2 shou	lete									24a. Was	an	24h Were	autonsy findi	nos available
_	: The la cate has	Completed									autor		prior t death 1 □ Y	autopsy findi to completion ? es 2 No	of cause of
VItal	ician certifi ector	B	25. Was case referred to medical examiner?	Hospital:				Othor			(Check only o				
0	Physician: this certific ral director,	2	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient of Injury	2 ER/Outpatie			4 ∐ Nŧ		me 5 Residence Reside I			pecify)	
	ding After funer	ion	1 Natural 5 ☐ Pendin) (Mo	nth, Day Y	ear) Zoo. Time Injury	м	28c. Injury Work?	es 2 🗆		zed, Describe i	iow injur	y occurred		
UIVISION	or Attenditer death	Certification:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be 28e. Plac	e of injury ding, etc. (l - At home, farm, s Specify)	-				28f. Location (S City or Tox	Street and vn, State	d Number or	Rural Route	Number,
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Ce		g Physician: To the		amination and/or									se(s)
	o the o the o the omple	Mec	29b. Signature and title of certifie		mer stated		25	9c. License	number			29d. Dat	e signed (Ma	onth, Day, Yea	ar)
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			30. Nan e and address person	who completed cau	ise of deat	h (Item 23a) (Tvn	Print)		ノヿ	1 1	\	JUI	Y X	,00	00
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	Sta		31. Date filed (Month, Day, Year)		Registrar's	Signature	Ann. B	8 0			7		100	-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 07:30 AM Frank James Wontrop Ju₁y 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21 Walden Court North East Ceci1 if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1**X** M 2 □ F 213-60-2002 June26, 1951 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Cecil North East Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Walden Court 21901 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married A Married TYPYES 2 No If Yes, Give 1971–73 Year or Dates: 1 ☐ Yes 2√√No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Concrete Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Joseph Wontrop Lorraine Pazdera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Diane Wontrop / Spouse 21 Walden Court, North East, Maryland 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Cemetery crematory or other place)
North EastMethodist
Cemetery XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doparton 5 ☐ Other (Specify) July 21, 5 Other (Specify) North East, Maryland 21. Signature o 22. Name and Address of Facility Crouch Funeral Home Mosio 127 South Main Street, North East, Maryland21901 Pm11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 24a. Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 25 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending

certificate be executed and P.O. Box 68760 the Division or Vital Records, certificate Physician: After this death. To the Hospital or Attence within 24 hours after death To the Funeral Director:

burial-t attending physician for use as the buria detached signed by the funeral director, the filled in by

Funeral

Director

28a-f show

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

3

Mental

s 1 and 2 s if Health an item 27 is r

permit. Pages the Department of Hamportant: If ite

Physician

/Medical

Examiner

any Injury or

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1 Natural 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check on one

29c. License number

29d. Date signed Month, Day, Year)

5+IVA

State Registrar

Medical

29b. Signature

31. Date filed (Month, Day, Year) JUL 2 2 2008

and title of certifier



38. Name and address of person who completed cause of death (Item 23a), (Type, Print)

State of Maryland / Department of Health and Mental Hygien 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:30 PM Bobbie Oliver Winn 7/20/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Yrs 84 7/10/1924 Director South Carolina 265-20-7177 Usual Residence of Decedent iiit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland screent of Health and Mantal Hygiene.

artent: if Item 27 is marked other then "natural; or items 23a or 28a-1 show 10d, Inside City Limits 10a, State 10c. City, Town or Location in then "natural", or iteme 23a or 28a-1 show the Medical Examinat must be notified at 10b. County 1

Yes 2□No Prince George's Riverdale Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20737 6814 Ingraham Street United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 X Yes 2 ☐ No 10. If Yes, Give Year or Dates: WWII White 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk U.S. Post Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Winn Clara Virginia Peeples 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Winn / wife 6814 Ingraham Street, Riverdale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State njury or 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 7/24/08 Alexandria, VA permit.
Deporte
Importe
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arosym a Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit fuse attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Cher (specify) 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Deabetes mellitere Non lasulen cliftendant (a) Hylasteason 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed End & tage revoil hisease dealesso dependent 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has Fraus negation (5 B80 certificete 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitei or within 24 hours a To the Funeral D Medicai 29a. Certifier 🏡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier istag mo 024720 7/20108 RAVINDER K. REESTAGI ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/32 LANDOVER ROAD, CHEV LANGOVER CHEVERLY 32. Registrar's Sign ture 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

2008

08-05502 Reuben Waugh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certificate o	of Death		Reg. N	lo. 20	08 2523
Physician ledical Examine	1. Decedent's Name (First, Middle,Last) Waugh			J	Date of Death Month Da Uly 17, 2008		3. Time of Death 2140 hrs
	4a. Facility Name (if r Prince Georg	ot institution, give street and number) e's Hospital		4b. City, Town, or Lo Cheverly	ocation of Death		4c. County of De Prince Geo	
Funeral Director	5. Social Security Nur. 579-42-58		yrs. last birthday)	If Under 1 Year Months Days	Hours Min	Date of Birth(N		Birthplace (State or Foreign Country) Washington, DC
any	Usual Residence of D		City, Town or Loc	ation				10d. Inside City Limits
	Distric	t of Columbia	Washin	zton 10f. Zip Code			Citizen of What C	1 X Yes 2 No
the Maryland a or 28a-f sh	10e. Street and Number 4273 Br	ooks Street, NE		20019		"	United S	
4D 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she smite event, the Medical Examiner must be notified at once	11. Marital Status 1 Never Married	2 Married Armed Forces? 1 X Yes 2 4 XDivorced If Yes, Give Year	No.	Vas Decedent of Hispa Yes, specify Cuban, I	Mexican, Puerto Ric		White, et	merican Indian, Black, c. Black
urs after ntural", aminer	3 Widowed	4 XDivorced If Yes, Give Year or Dates: cation (Specify only highest grade complet	ed) 16a. Deced	Yes 2 X No ent's Usual Occupatio most of working life. D	n (Give kind of work		Specify: b. Kind of Busine	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other trannatic event, the Medical Examiner.	Elementary/Secon	dary (0-12) College (1-4 or 5+) 4 years		Counselor	JO NOT use reares,		Governme	ent
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica		irst, Middle, Last)		18	B.Mother's Name (Fi			
2121 ould be fil d Mental Is s marked fic event,		E. Waugh, Sr. ne/Relationship (Type, Print)	19b. Mai	ing Address (Street				State, Zip Code)
MD d 2 shot lth and n 27 is numarite	Gregory W	augh - Son		l Atlantic				
or Heal	20a. Method of Dispo 1 XBurial 2	osition Cremation 3 Removal from State	crematory or		,			y or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr	21. Signature of Food	Other Specify:		coln Cemet				
Bal permi Depa Impo injur	1 MARI	M. WITTOWNE	1 1 4	001 Bennin	g Road, N	IE Washi	ngton, 1	
Physician	23a. Rart I. Enter the failure. List only	disease, or complications that caused the one cause on each line.	death. Do not ente	r the mode of dying, s	uch as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical 	Immediate Cause (F or condition resulting			bolism				Death
	Sequentially list con-	ditions, b. bilateral	deep vei	n thrombos	is			
	if any, leading to immore cause. Enter Underland (Disease or injury the events resulting in decided)	lying Cause						
uted id ansit		eath) Last Due to (or as a conseque						
760, Toate be executed physician and the burial - transit	X UNPENDED IF FEMALE:	AMENDED 23a,	PII,27,p	erME, g882	8/11/08	TT		
68760, certificate be ording physicis se as the buria			of pregnancy	Fetal death 3	Ectopic pregnanc	у	23d. Date of de Month	livery Day Year
Box 68's death certiff	past 12 months? 1 Yes 2 No	4 Pregnant at time	e of death 5	Other (Specify)				
P.O. Bost that the degree by the detached for the detache		cant conditions contributing to death bu						te to the cause of death? Probably 4 Unknown
IS, P.C	Hypert	ensive atherosclero				24a Was an		re autopsy findings available
of Vital Records, P.O. Box 68' in Physician: The law requires that the death certifulate this certificate has been signed by the attending meral director, page 2 should be detached for use as	Hypert polycy	thermia, chronic ob	structiv			performe 1 V Yes 2	ed? dea	or to completion of cause of ath? Yes 2 No
Vital Reorysician; The his certificate director, page	25. Was case referred examiner?	Hospital:	2 ✔ ER/Outpati	10	of Death (Check on Other, Nursing I		esidence 6	Other:
ion of Vital I tending Physician: oesth. the funeral director,	27 Manner of Death	INO	28b, Time	of Injury 28c. Injury	y at Work?		w injury occurred	
Division tal or Attendii rs after death. al Director: /	1X Natural 2 Accident	5 Pending Investigation			es 2 No	Rf Location (Str	et and Number	or Rural Route Number, City
Divisio Division Sepital or Attenthours after deat thours after deat thereal Director filled in by the	1X Natural 2 Accident 3 Suicide 4 Homicide	6 Could not be determined (Specify)	- At nome, farm, s	treet, factory, office bu	alloning, etc.	or Town, Stat		
	29a. Certifier	Certifying Physician: To the best of my kr Medical Examiner: On the basis of examina and manner stated.	nowledge, death or ation and/or invest	curred at the time, dating ation, in my opinion,	te and place, and do death occurred at t	ue to the cause(he time, date an	s) and manner as d place, and due	s stated. to the cause(s)
To viit	29b Signature and			29c. License			29d. Date signed	(Month, Day, Year)
	30. Name and address	ess of person who completed cause o deat	h (Item 23a)	0.0.1				
7	Zabiullah Ali	, M.D. Assistant Medical Exar	miner 111 P	enn Street, Balti	more, MD 2120	01		
Sta Registr	te 31. Data filed (Nonti	Day Years 32. Registrate	Signature	,				

08-05545

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25240

Maurice James V	1	- For State	Stat	e of Maryland	l / Depa <i>Cer</i>	rtment of <i>tificate of</i>	Health Death	and	Menta	ıl Hyg		Reg. No.		00	8 2521
Physicia	ın/	Registrar 1. Decedent's Name	(First, Middle,L	ast)						2.	Date of De		Year	3	Time of Death
Medical Examin	ner	MAURI	CE JA	MES WII	LIAMS		th O'r Tarre	1-	antion of I		July 20,	2008	c. County of	Death	0225 hrs
		4a. Facility Name (if Washington		give street and numbe spital	er)		Hagerst		Cation or i	V				on	
Funeral		5. Social Security N	umber 6.	Sex 7. /	Age (In yrs. la	ast birthday)	If Under 1	Year Days	If Under :	24Hrs. Min.				Cour	olace (State or Foreign
Director		218-21-7		XM 2 F	27	Yrs					MAY	21 1	981	MAR	ÝLAND
any		Usual Residence of 10a. State	10b. County		10c. City,	Town or Local	ion		-		-				0d. Inside City Limits
≥	٦	MD	MONTGO	OMERY SILVER SPRING									1 X Yes 2 No		
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Wr USA									t Count	y?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	١								Americ	an Indian, Black,					
ath wi items	Funeral	11. Marital Status 1 XNever Marrie	ed 2 Marr	Armed Cores		lf Y	es, specify (Cuban, f	Mexican, F	Puerto R	ticán, etc.)		White,	etc.	
after de	by Ft	3 Widowed		ced If Yes, Give Year or Dates:			Yes 2					Len	Specify: BLACK Kind of Business/Industry		
hours a	ed b			y only highest grade of College (1-4		16a. Decede during n	nt's Usual Oc nost of workin	cupationg life. D	n (Give kii OO NOT u	nd of wo	ork done (d)	160.	Kind of Bus	iness/in	dustry
36 hin 72 e. than "	Completed	Elementary/Second 12t		College (1-4	01 51)	SEC	URITY	GUA	RD]		PRIVAT	E	
5-00 ed with tygien other the Me	Con	17. Father's Name	(First, Middle, L	ast)		<u> </u>		18	3.Mother's	Name (First, Middl	e, Maide	n Surname)		
121 d be fil lental F arked	o Be	KENNETH 19a. Informant's Na	J. WI	LLIAMS		19h Mailir	ng Address	(Street	S:	HARC er or Ru	N E.	BROV lumber.	VN City or Towr	n, State,	Zip Code)
ID 2 should and M and M matic	ĭ	SHARON E					-								20910
e, N 1 and 2 Health item 2	-	20a. Method of Dis	position			Place of Dispo	sition (Name	of ceme	etery,		Date	200	c. Location -	City or	own, State
MOF Pages ent of int: If			Other Spe	3 Removal from	RE	SURRECT	CION C	EMET	ERY						ARYLAND
Salti ermit. epartm nports ijury o		21. Signature of Fu	ineral Service L	icensee			Name and A								RAL HOME 20785
		23a, Part I, Enter th	ne disease, or c	omplications that caus	sed the death	n. Do not enter	474 L	ANDC dying, s	UCh as ca	ROAL rdiac or	respiratory	arrest, s	hock, or hea	IT LAN	Approximate Interval Between Onset and
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest a. Gunshot Wound of Chest													
aminer		or condition resulting in death) Due to (or as a consequence of):													
	e.	Sequentially list co	onditions, nmediate	b Due to (or as a co	onsequence o	of):									
	Examine	(Disease or Injury	erlying Cause that initiated	c. Due to (or as a co	onsequence o	of):									
uted nd ransit	Ĕ	events resulting in	deatn) Last	d											
50, te be executed ysician and burial - transit	edical	UNPENDE)	AMENDED											
3760 ificate l	an/Me	IF FEMALE: 23b. Was deceden		23c. If yes, ou			etal death	3	Ectopic	pregna	ncy	1	23d. Date of Month		y Oay Year
Records, P.O. Box 68766 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the t	sicia	past 12 month			nt at time of d	eath 5	Other (Specia	fy)							
b. Bc the dea	Phy	Part II. Other sign		9 Olikilow		resulting in the	underlying (ause gi	iven in Pa	rt I.	23e. D	id tobac	co use contr	ibute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ra after death. In allor educath. In Director, After this certificate has been signed by led in by the funeral director, page 2 should be detach.	l b	L									1	Yes 2	√ No 3	Prot	pably 4 Unknown
rds, requir	Completed											utopsy		orior to	topsy findings available completion of cause of
teco The law ate has	8					-						erformed es 2		death?	es 2 No
ian: 1	Be C	25. Was case refe	rred to medical	Hospital:					of Death Other		only one) g Home 5	Por	sidence 6	Othe	
n of Vital ding Physician: After this certif : funeral director,	[2	1 Yes	2 No	28a Date of	Injury	ER/Outpatie			y at Work	?	28d. Descr	ibe how	injury occur		
On O anding ath. rr: Aft	ţi	1 Natural	5 Pend	ing FOUND:	Day,Year)	FOUND: 0159 hrs		1Y	'es 2 🗸	No	Subject :				
ivision I or Attend after death. Director:	Certification:	2 Accident 3 Suicide	6 Could	not be 28e. Place	of Injury - At	home, farm, st		office b	uilding, et	c.	28f. Locati or Tov	on (Stree	et and Numb e) ek, Hanove	er or Ru	ral Route Number, City
DIVI E Hospital or 24 hours afte e Funeral Die etely filled in	Ser	4 Momicide				ad / Highwa					_	-07			
	Medical		Certifying Ph Medical Exar	ysician: To the best miner: On the basis of	examination	age, death occ and/or investi	pation, in my	opinion	, death oc	curred a	at the time,	date and	place, and	due to th	ne cause(s)
To the within To the comple	Med	29b. Signature an	d title of certifie	and manner sta	ited.		29c.	Licens	e number			25	9d. Date sign	ned (Mo	nth, Day, Year)
3		1/1	and	who ell	/)			O.C.I	M.E.			J	uly 20, 20	800	
(6)				who completed cause			nn Street,	Baltin	nore M	ID 212	201			V	
		Laron Lock		ssistant Medical				Jaili							
Regio	State	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3 2008	Ragina	#	the state	•								

ORIGINAL

2008

4c. County of Death

USA

14. Race - American Indian,

Black. White, etc.

Specify: White

23d. Date of delivery

29d. Date signed (Month, Day, Year)

7207-B Hanover Pkuy, Greenbelt, MD 20770

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

10:01 A M

9. Birthplace (State or Foreign

Washington, D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month David J. Wineberg 21, July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery County 8. Date of Birth (Month, Day, Year) July 15,1927 if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★M 2 □ F 214-28-4718 81 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Directo MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Kegwood Lane 20715 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examinar minatural. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1 946-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Project Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd W. Wineberg Isabell McQuown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Wineberg/Spouse 2501 Kegwood Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem. 7/28/2008 Crownsville, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner SPIRA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed HRONIC attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical INFECTION IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Josephan 24 hours after death.

Funeral Director: After this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 npatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the

State Registrar 29b. Signature and title of certifier

Mandra Gra pati 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD 5L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 21 per ab 882 82 82 7 68 8 Health and Mental Hygiene 0 0 0

			for State Registrar	State or wa	ar yl anor/		tificate of		a Mentai Hy	Reg. No.	8008	25242			
	Physici	an	1. Decedent's Name (First, Middle, La.	st)					2. Date of De Month	ath Day	Year	3. Time of Death			
	/Medi	cal	Jerry Allen						7	26	2008	19:32 M			
)	Examir Funeral	er	4a. Facility Name (If not institution, given by the May a 5. Social Security Number 15. Social Securit	nd Udica	al Carr e (In yrs. last b		4b. City, Town, of Bahy If Under 1 Year Months Days	MMC If Under 24			9. Birthp	elace (State or Foreign			
	Director		307-30-4030	X M 2□F	64	Yrs.			Jan 19	1944					
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				10	0d. Inside City Limits			
	Mary a-f sh	ģ	MD Anne Aru	nd e1		Pas	adena					1 □ Yes 2√ No			
	or 28	Sire	10e. Street and Number		ļ		10f. Zip Code			10g. Citizen	of What Coun	itry?			
	ath wi	ral	8435 Geneva Road				2112				USA				
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. 9d other than "natural" or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2[X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Vas Decedent of I fYes, specify Cub I∐Yes 2∑No		? (Specify Yes or No uerto Rican, etc.)		Race - Americ Black, White, e ecify: wh				
5-0	72 ho	eted	15. Decedent's Ec	ducation	16	a. Dece	dent's Usual Occup	pation during most of	working unk	16b. Kind o	of Business/Inc	dustry unk			
121	within ene. than "	Completed	Elementary/Secondary (0-12)				kind of work done OO NOT use retire	d)							
Maryland 2	hould be filed and Mental Hygi marked other matic event, II	Be	17. Father's Name (First, Middle, Last,				unk	18. Mother's	Name (First, Middle	L , Maiden Sur	rname)	unk			
aryl	0 = 10 3	မ	19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailir	g Address (Street	and Number o	r Rural Route Numb	er, City or To	wn, State, Zip	Code)			
	od 2 ulth a 27 is		University of MD	Medical C	tr	22	S. Green	Street	Baltimor	e, MD	21201				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specif	Removal from State in state	1	of Dispo tery, cren	sition (Name of natory or other pla	ce)	Date	20c. Locati	on - City or To	wn, State			
Balt	permit. Page Department of Important: If any Injury or sance.		21. Signature of Funeral Service Licer Ronald S.	Wade, Dire	ector per dvr	St	Name and Address ate Anat ltimore,	omy Boa	rd 655 W.	Balti	more S	treet			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li	the death. Do	o not ent	er the mode of dyi	ng, such as car	diac or respiratory a			Approximate Interval Between Onset and Death			
	tificate be executed ig physician and as the burial-transit	Il Examiner				Gaussially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence	e of):	tracrar	nai n	meurysi			4 weeks
68760,	ficate physi s the b	Aedical		d											
O. Box	The law requires that the death certifin to the bean signed by the attending to age 2 should be detached for use as	Physician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnand Other (specify) _	су		23d.	. Date of delive Month	ery Day Year		
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the ur	nderlying cause giv	ven in Part I.		tobacco use o Yes 2 □ N		ne cause of death?			
I Records,		Completed							— auto	24a. Was an autopsy autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 ☑ No					
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	119-1			T		Death (Check only	one)					
of	Phys this	on: To	1 ☐ Yes 2 ☐ You 27. Manner of Death 1	Hospital: 1 Impatie 28a. Date of Inju (Month, Da	ent 2 ER/0	Outpatier Time of Injury	t 3 DOA Oth	ry at	ng Home 5 ☐ Res 28d. Describe			<i>y)</i>			
Division	or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	Place of Injury - At home, building, etc. (Specify)]Yes 2□No	28f. Location		(Street and Number or Rural Route No own, State)				
	Hospital or 24 hours afte Funeral Dir letely filled in	ledical C	29a. Certifier (Check only one) (Check only one)	nysician: To the best niner: On the basis o and manner st	f examination a	ge, deatl and/or in	n occurred at the t vestigation, in my	ime, date and p opinion, death o	place, and due to the occurred at the time	e cause(s) an , date and pla	d manner as s ace, and due to	itated. the cause(s)			
	To the I within 2 To the I complet	Me	29b. Signature and title of certific	1			29c. Licens	se number		29d. Date si	igned (Month,	Day, Year)			
			1//	/n	10		18	3141		7	126/20	800			
			30. Name and address of person who	completed cause of d	1) (Type,	Print)	R., 14	more, I	10	2120				
ı	Sta Registr		31. Date filed (Month, Day, 1997)	008 32. segistr	ar's Signature	A	rede	1000	TANCOLC , I						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** РΜ August 4, Elizabeth Jean Atcherson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Hospice of the Chesapeake Harwood 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 □ M 2 🔀 F 84 Feb. 1924 Minnesota 6, Director 472-20-3857 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ns 23a or 28a-f show 1 X Yes 2 No Director Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. IISA 20716 2215 Harwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X☐
If Yes, Give
Year or Dates: 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify þ Specify: er than "natural", 3 Widowed 4 Divorced USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered Nurse 7 Is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Hartwell Todd Doughty Elsie Chamberland ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2215 Harwood Lane Bowie, MD 20716 Department of Health Important: If item 27 any injury or other trong. Samuel Meadows Atcherson/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burlal-tran Due to (or as a consequence of): ttending physician or use as the burla Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation ithin 24 hours after death.

the Funeral Director: Af
ompletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Chec and manner stated. within 2 29d. Date signed (Nonth, Day, Year) 29b. Signature 2000 Navi e and State 6 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:30 GCM 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KaltiMore Ellinwood nasadale Keag Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1**X**M 2□F Months 40 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant; If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Kusedale 1 XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ellinwood by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 📉 No Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other trainmate. condary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname Be 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ac ral Route <u>N</u>umber, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Md. 21221 National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 4 Unknown cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an certificate RC 1 Yes 2 ✓ 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

> State Registrar

31. Date filed (Month, Day, Year) AUG 0 6

29b. Signature and title of certifier

30. Name and address of person

29a. Certifier (Check only

32. Pegistrar's Signature

2008

use of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 8:09 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** 1 □ M 2 🗓 F Months 72 Director 216 32 1686 08/25/1935 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show unt; If item 27 is tranked other than "natural", or Internatinal in with the Unit of Natural Internation of Natu 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Anne Arundel Glen Burnie Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 205 Maple Avenue 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Mrozek Angela Polonoski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Maple Avenue Glen Burnie, Maryland 21061 Charles Brocklehurst / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 □ Donation Meadowridge Mem. Park 08/06/2008 5 ☐ Other (Specify) 21. Signaturi f Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Ritchie Highway 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 1001 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No7 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 □ Yes 2 🗷 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) W on who completed cause of death (Item 23a) (Type, Print) 401 bar WD State 31. Date filed (Month, Day, Year) 2. Registrar's Signature D Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 - State Amend #26, per verbal G882 8/6 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Glenda Ballard 30 08 5:30 PM Η. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore erlYear | If Under 24 3909 Batem<u>an Ave</u>. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 94 7-24-1914 Director 220-10-6321 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, Il to Mexical Examiner must be notified at Director 1 XYes 2 ☐ No Md N/A<u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2444 Terra Firma Rd. 21225 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Edward Harris Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ballard (Spouse) 2444 Terra Firma Road, Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Remoyal from State Garrison ForestVet.8-5-08 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep BrothersFSPA, 21. Signatu e of Funeral Service 1300 Eutaw Place, Baltimore, Md. 21217 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My cardial Tomorron **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Dementre Alzheimer's and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 😾 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · anile Chandelion DODS 2490 6,2008

Registrar
DHMH 17 Rev 1/2001

State

SOUK HANOVE

21225

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BAltonion

St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Khandelwal

31. Date filed (Month, Day, Year)

3001,

32. Regiorar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Term State of Maryland / Department / Department / Departme	artment of Health and N		ene g. No. 2008	3 25250						
je m	Physici /Medi		1. Decedent's Name (First, Middle, Last) MARION BERNSTEIN		Date of Death Month		3. Time of Death 230 A M						
V.	Examir		4a. Facility Name (If not institution, give street and number) Lorien Columbia	4b. City, Town, or Location of Death Columbia	V /	4c. County of Deat	4c. County of Death Howard						
	Funeral Director		5. Social Security Number 215-07-8541 Usual Residence of Decedent 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Year) Co	9. Birthplace (State or Foreign Country) Pennsylvania							
Ind 21215-0036 be filed within 72 hours after death with the Maryland Ital Hygiene. dother than "natural", or Items 23a or 28a-f show	ie Maryland 8a-f show tiffied at	Director	MD Howard 10c. City, Town or Lo	10c. City, Town or Location Columbia									
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Balt	permit. Pag Department Important: I any Injury o		21. Signature of Furreral Service Discrete Ronald S. Wade. Discretor State Anatomy Board 655 W. Baltimore S. Baltimore, MD 21201										
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	To T Com	Σ	29b. Signature and title of dartifier M.)	29c. License number D 6 6 6 2 6 3 4	-	d. Date signed (Mont	(p						
- 2	Sta	to.	30. Name and address of person who completed cause of death (Item 23a) (Type, MATESA AUAN (0802 31. Date filed (Month, Day, Year) AUG 0 6 2008 32 Registrar's Signature	HICKURY RIDGE	20 (0	LUMBIA	MD 21.44						
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			for State Registrar		State of M	aryland		tificate of	Death	vientai Hy	Reg. No	20	08	2525	
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	Examin	er	4a. Facility Name (If not ins	-			=		r Location of Death	1	-	c. County rince		rae	
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Οį	after dans die dans d	Certification: To	4 ☐ Homicide	determined	building, e	tc. (Specify))	eet, factory, office		City or To	own, Sta	te)	er or nare	al Modite Humber,	
	e Hospita 24 hours e Funeral letely filled	Medical C			hysician: To the besiminer: On the basis and manner s	of examinati tated.	ion and/or in	vestigation, in my	opinion, death occ	urred at the time	e, date a	nd place,	and due t	o the cause(s)	
	withir. To the	Me	29b. Signature and title of		0			29c. Licen:	se number		29d. D	ate signe	d (Month,	Day, Year)	
	~		Mucha	ul 1	Derard	, Ru		0	26284	(71	31/	80		
	6t1		30. Name and address of Mich AE	1 7	completed cause of	death (Item	23a) (Type,	Print) BALTIMO	se number 76284 RE BIV	i) (Coll	ege	Par	1c mi)	
	Sta Registr		31. Date filed (Month, Day		32 Regist	trar's Signatu	re A	ande		-					
	negisti	CAL .	אערו		3	-	ST CARE								

Casterline, Arnold, patrick

Registrar DHMH 17 Rev 1/2001

State

ERNESTINE WRIGHT

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2008

AUG 0

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** SARATH /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner natown 8. Date of Birth 9 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. lase **Funeral** Min. Hours 1 □ M 2 💢 F Months Days Director Vla Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Ire Medical Examiner must be notified at once. by Funeral Director nore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 🌠 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disnosition Date 1 Burial 2 Cremation 3 Removal from State 2008 4 Donation 5 □ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service/Licensee 23a. Part / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ATT-TENOSI LEVIETT () stret disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MENNA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: Medical Certification: To 1 ☐ Yes 2 N 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After i 1 √ Matural 5 Pending 1 ☐ Yes 2 🗌 No 2 Accident investigation Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 1 NO

29d. Date signed (Month, Day, Year)

Suite 308, BALTIMOR

Year

1 Yes 2 No

Division of Vital Records,

within 24 hours after death To the Funeral Director:

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

32. Registrar's Signature

r🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

08-05689 Patrick Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25255

			1- For State Certificate of Dea	th	Reg. N	lo.	
**	Physicia	ın/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Da July 24, 2008	y Year	3. Time of Death 2126 hrs
vr-	deal Exami		Patrick T. Davis 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of Death	
			ta. I don'ty rame (in terminal	verly		Prince George	
	Funeral			der 1 Year If Under 24Hrs		IM/DD/YYYY) 9. Bir	thplace (State or
	Director		579-17-1549 1XM 2 F 18 Yrs. Mon	ths Days Hours Min	08/31/	1989	Washingtor DC DC
	A	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ow any		Tod. Oldie	gton, DC			1 X Yes 2 No
0	yland a-f sh	흱		ip Code	10g.	Citizen of What Cou	intry?
à	th the Maryland 23a or 28a-f sho notified at ouce.	Director	2701 Langston Place, S.E.	20020		USA	
0	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Married 2 Married 3 Armed Forces? 1 X Never Married 4 Married 5 Married 6 Married 7 Married 7 Married 1 Mar	dent of Hispanic Origin? (S cify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
	r deat or ite	ᇤ	1 Yes 2 X No	2 X No specify:		Specify: B	lack
	rs afte ural",	ā	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu.	al Occupation (Give kind of		b. Kind of Business	
	2 hou "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	vorking life. DO NOT use ref	ired)		
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours af neut of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin	Completed	12 Stud	ent		Private	
	5-0 iled w Hygie I othe		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	Davis	
	121 d be f fental narked event,	o Be	James Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	Chris ess (Street and Number or			e, Zip Code)
	Shoul shoul and N	· - 1		ngston Plac			20020
	Baltimore, MD oremit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 20b. Place of Disposition (N	lame of cemetery,		0c. Location - City o	r Town, State
	ages l nt of l t: If i		1 X Burial 2 Cremation 3 Removal from State		5/08 V	Vashingt	on, DC
	nit. Partment artment ortan		21. Signature of Funeral Service Licensee 22. Name a	nd Address of FacilityAG	EE/MCKIN	NON Fund	eral Servi
	Balt permit. Depart Impor		3821	14th Stree	t,NW,Was	shington	,DC 20011
1	Physician	V	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	de of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
às.	Wedical aminer		Immediate Cause (Final disease a Occlusive coronary arte	ry thrombus			Death
	(31111151		or condition resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):				
	ted 1 ansit	Ä	events resulting in death) Last				
	execu an an	Medical	x unpended	2 8/18/08 TT			
	68760, certificate be executed anding physician and use as the burial - transit	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	
	687 ertific ding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other /5		nancy	Month	Day Year
	Box 687 e death certific the attending of for use as the	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (S	specny)	-		
	Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certificate hours after death. 24 hours after death. The law requires that the death certificate has been signed by the attending teldy filled in by the funeral director, page 2 should be detached for use as t	H		ying cause given in Part I.			to the cause of death?
	Records, P.O. I The law requires that the icate has been signed by the page 2 should be detache	d by			1 Yes		obably 4 Unknown
	Division of Vital Records, tal or Attending Physician: The law require and red earth. "In Director: After this certificate has been sized in by the funeral director, page 2 should b	Completed			24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
	eco ne law te has ge 2 s	Ĕ			perform 1 V Yes 2		
	nr. Tr. rriffica tor, pa	ပြိ	25. Was case referred to medical	26.Place of Death (Chec	k only one)		
	Vita ysicla this ce	0.0					ner:
	of ng Pl	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
	tendi teath.	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	20f Leastion (St	root and Number or	Rural Route Number, City
	ivisior I or Attend after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	tory, office building, etc.	or Town, Sta		rtoral rtode rtombol, oxy
	Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. completely filled in by the funeral director.	5		t the time, date and place, a	nd due to the cause	(s) and manner as s	tated.
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in	n my opinion, death occurre	d at the time, date ar	nd place, and due to	the cause(s)
_	To the within 2 To the complet	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (
			Lock Medon	O.C.M.E.		July 26, 2008	
			30. Name and address of person who completed cause of death (Item 23a)				
	OT		Tacha Greenberg MD Assistant Medical Examiner 111 Pen	ın Street, Baltimore, I	MD 21201		
		State	11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? ,			
	Regi	stra	AUG V 6 ZUU8 Denser Jos Apare	New Control of the Co			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 25, GRACE CLAUDIA DIGGS July 2008 9:15AM^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3001 Queens Chapel Road, #216 Hyattsville P.G. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 04 / 1914 9. Birthplace (State of Foliaign 6. Sex Social Security Number 223-40-8891 1 □ M 2 □ XF Months Days Hours Min. Huntington, VA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits P.G. Hyattsville 1∰Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 3001 Queens Chapel Road, #216 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Black 1 ∐Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) V.A. Hospital Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kitty Mae (unknown) Bubba Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 6616 Greenvale Parkway 0737 Arlene Diggs/Daughter-in-law Tate 29 / 080c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Brentwood, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee <u> 3821 - 14th Street, N.W.,</u> Washington, DC Approximate 2011 Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Ca (Final disease or condition resulting in death) Due to (or as a consequence Due to for as a consequence Due to (or as a If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No

Physician /Medical Examiner

Department of Health Important: If item 27 any injury or other troone.

Physician

/Medical

Examiner

Director

Funeral

ģ

MD

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, it o Madical Examiner must be notified at

death

filed within 72 hours after

I Hygiene.

. Pages 1 and 2 should be filk tment of Health and Mental H tant: If item 27 Is marked oth

Maryland 21215-0036

Baltimore,

Exami Physician/Medical à Completed

sician and burial-tran attending physician for use as the buria as ed by the detached f signed by t I be detach s peen s certificate has page 2 Certification; To this After thi To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral

law requires that the death certificate be executed

Box 68760,

P.O.

Records,

of Vital

Division

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0 6 2008

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

29c. License number

29d. Date signed (Month, Pay,

DHMH 17 Rev 1/2001

Registrar

TORNE !

eted cause of death (Item 23a) (Type, Print) 7500 Hanover

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Roger Anthony Dennis State of Maryland / Department of Health and Mental Hygiene 2008 25257 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 1631 hrs ROGER A. DENNIS JR, August 1, 2008 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death 3207 Saint Ambrose Avenue Baltimore N/A8. Date of Birth (MM/DD/YYYY 5. Social Security Number If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country) MD. XM 25 6/4/83 17 4078 216Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 No BALTIMORE MD. N/A death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 3207 ST. AMBROSE AVE. 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 11. Marital Status White, etc. 1 X Never Married 2 Armed Forces' Married Yes Divorced If Yes, Give Year BLACK 1 Yes 2 X No specify: Specify: ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A NONE DISABLE 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ROGER A. DENNIS SR. THERESA DENNIS Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS THERESA AMBROSE AVE. BALTO. MD. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date Baltimore, crematory or other place) 1 X Burial 2 Cremation Removal from State 8/9/08 KING, S PARK RANDALLSTOWN, MD. mportant Other Specify 21. Signatur of Puneral Service Licensee Name and Address of Facility
ESTEP BROS FUNERAL
1300 EUTAW PL. BAL МР:^А21217 23a. Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Complications of gunshot wounds of torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical #1 as noted, 23a,27,28a-f, perME, g883 9/18/08attending physician a X UNPENDED X AMENDED Box 68760. IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d, Date of delivery 3 Ectopic pregnancy Live birth Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other4 examiner? lospital: DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred n 24 hours after death.
e Fineral Director: A letely filled in by the fu Natural 1 Yes 2 X No Pending 5/27/1996 unk subject was shot 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State)
BAltimore. determined To the Funeral (Specify) X Homicide unk 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E August 2, 2008 30. Name and address of person who completed cause of death (Item 23a)

Ober

Melissa Brassell, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

ORIGINAL

31. Date filed (Month)

State of Maryland / Department of Health and Mental Hygieney For State Registrar 25258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 2008 July **Physician** 31, Colleen 9:12 □ Mae Davis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 804 Overbrook Road 8altimore 8altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Feb 27, 1925 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Maryland 1 □ M 2 🔽 F 219-10-1807 83 Yrs. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examinar must be redified at MD **Baltimore** Baltimore 1 ☐ Yes 2 ☐XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Overbrook Road U.S.A. 21239 Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after Hygiene. 1 ∐Yes 2√∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cafeteria/Baltimore and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager County Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any lipluy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spurrier Dennis Harry Richard Ethel ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1329 Dalton Rd., Baltimore, MD Deborah Davis-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park 8/5/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 11111am 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. G. Dau 1050 York Rd., Towson, MD Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical disease /strokes Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 □ Yes 2 No 2 NO 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Str 203 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

			1 - State of Maryland / Dep Amend Items 23a per dr, 88	artment of Health and 32,08/05/08dhb rincate of Death	Mental Hy	giene Reg. No. 200	8 2525
V	Physic /Med		1. Decedent's Name (First, Middle, Last) Geraldine D.	Feuerherd	2. Date of Dea		3. Time of Death
	Exam	iner	4a. Facility Name (If not institution, give street and number) 418 Kingwood Road 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	4b. City, Town, or Location of Dea	th	4c. County of E	Peath Arundel
	Funera Director		219-20-6731 1	If Under 1 Year If Under 24 Hrs Months Days Hours Min		y, Year)	Birthplace (State or Foreig Country) laryland
	th the Maryla or 28a-f show	Director	Maryland Anne Arundel Linthicum 10e. Street and Number			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2X☐ No Country?
Baltimore, Maryland 21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education 16a. Deced	21090 Was Decedent of Hispanic Origin? (See Yes, specify Cuban, Mexican, Puer I Yes, 22 No Specify: dent's Usual Occupation	Specify Yes or No- to Rican, etc.)	USA 14. Race - A Black, W	merican Indian, Thite, etc. White
ld 2121	filed withir Hygiene. ther than		Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work done during most of work done during most of work done during most of work during most durin		Own Hom	e
arylan	d 2 should be th and Mental 7 is marked o traumatic eve	To Be	Edward Eckart, Sr.	Viola g Address (Street and Number or Re		Calhou	
re, Ma	t and 2 Health a em 27 is		Wayne C. Feuerherd (Son) 200 N	. Hammonds Ferry	Rd., Lin	thicum, M	D 21090
Baltimo	permit. Pages. Department of I Important: If ite any Injuly or of once.		4 □ Donation 5 ☒ Other (Specify) Entombment Loudon Pa 21. Signature of Funeral Service Licensus 22.	ark Cemetery 8/1/ Name and Address of Facility Lo 520 Wilkens Ave.,	08 udon Parl	Baltimore k Funeral	, Maryland Home
	Physician be executed /Medical standing the purial-transit standing the purial transit standing tra	dical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	achere	or respiratory arm	est,	Approximate Interval Between Onset and Death
. Box b	deatn certi e attending d for use a	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year
ecords, P.	as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob		to the cause of death? Probably 4 🗆 Unknown
	ate h	e Completed	25. Was case referred to medical		24a. Was an autopsy perform 1 □ Yes 2	y prior t <u>ned</u> ? death	autopsy findings available o completion of cause of ? es 2 \(\square\) No
5 8	this	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	h <i>(Check only one</i> me 5 Resider	e) nce 6 ∐Other (S _k	pecify)
DIVISION OF A PARTIES	within 24 hours are restrained. To the Funeral Director: After completely filled in by the funeral process.	Certification:	At large state Sample Pending (Month, Day, Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe hov		
Penital or	within 24 hours after deat To the Funeral Director. Completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge death of	Occurred at the time date and slave	City or Town,	State)	Rural Route Number,
Co the Ho	vithin 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inversal and manner stated. 29b. Signature and title of certifier	estigation, in my opinion, death occur	red at the time, da	ite and place, and di	ue to the cause(s)
	(9)		30 Name and address of person who completed cause of death (Item 23a) (Type, Pr	D50517	29	d. Date signed (Mor	
	Stat	0	overory Levillog 11201	V. Kolling RS	Sal	to Mo	71228
	Registra	•	31. Date filed (Month, Day, Year) AUG 0 5 2008 32. Registrar's Signature	a)			

			For State	State of M	larylan		rtment of F tificate of	Health and M Death	lental Hygi	iene	18	25260
			Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of Death	n		3. Time of Death
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and a	/Medic Examin		4a. Facility Name (If not institution,		.1		egory 4b. City. Town, o	r Location of Death		4c. County of		4:12 -
	LAGIIIII	GI	524 N. Charl		' Api	804	Baltin			N/A	4	
	Funeral			6. Sex 7. A		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		218-36-9231	1□ M 2\ F	69	Yrs.	Months Days	Hours Min.	8-23-		Count	MD
	pu ,		Usual Residence of Decedent						7 7 7 7		10	d. Inside City Limits
	aryla shov	ا م	10a. State 10b. County	37 / T		, Town or Loc					10	1. Tyes 2 No
	be M	Director	MD	N/A		altimo	10f. Zip Code		14	og. Citizen of Wh	ant Count	23
	a or		10e. Street and Number		Apt 8	304	Tot. Zip Code		"		iai Count	y i
	reath	era	524 N. Charl 11. Marital Status	es Street		S 13 V	Vas Decedent of H]] Hispanic Origin? (Sp	ecify Yes or No-	U S A	- America	an Indian
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036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examinar most ke rodined at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, GiveX Year or Dates:		1	□Yes 2XNo	Specify:		Specify:	Bla	ack
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	ed wi	S	12th grade	2 yea	ars	Di	sabled			Disabl		
pu	be fill	Be	17. Father's Name (First, Middle, L.	ast)				18. Mother's Name			,	
<u>\</u>	should and Men s marke umatic	ျ	John Eaton			T			hy Nick			
Maryland	12 sh shand 7 Is n traun		19a. Informant's Name/Relationshi Theodore Greg		n d	1		and Number or Run				2 - 2
	1 and 2 Health a tem 27 Is		20a. Method of Disposition	OLY HUBBU	20b. P	lace of Dispos	sition /Name of		Date 2	20c. Location - C		
100	Pages nent of I ant: If Ite ury or o		X\sqrt{Burial} 2 \sqrt{Cremation} 3 4 \sqrt{Donation} 5 \sqrt{Other} (Specific Specific ☐ Removal from State	Ar	emetery, crem butus	matory or other place. Memoria	(al 8-9-	2008	Arbutu	-		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Lear-sittled at once.		21. Signature of uneral Service L	11.1		22	. Name and Addre	ess of Facility	March F	/H Ea	st	
<u> </u>			Allen Ille	well		-	1101	E. Nort				MD 21202
			23a. Part 1. Exter the disease, or c shock, or heart failure. List o	omplications that cause	ed the death	. Do not ente	er the mode of dyin	ng, sich as cardiac	respiratory arre	est,		Approximate Interval Between
E No.	Physician		Immediate Cause (Final disease or condition	. Sud	Jen	Car	1200	xearl	I			Onset and Death
	/Medical		resulting in death)	Due to (or as	s a consequ	ience of):	11 1	1 -1	. 1	ale	2 4	Seconde
	Examiner	_	Sequentially list conditions,	b. ##//	you,	ma	OCHU	reroscie	erotic	MAXI	16	seconds
	ted isit	nin	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	a consequ	ience or):			V			
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8760,	icate be executed physician and the burial-transit	dical	1	d								
Φ	rtifical ng phy as th	ledi								1	-	
Box	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 \sum Live birth	e of pregna	ncy death 3□	Ectopic pregnanc	:v		23d. Date		·
О.	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of d	eath 5□	Other (specify)			Mont	ו חג	Day Year
σ.	hat the		Part II. Other significant condition	s contributing to death	hut not resu	ulting in the un	iderlying cause giv	en in Part I	23e. Did tob	acco use contrib	oute to th	e cause of death?
Records,	The law requires that the ate has been signed by thoage 2 should be detache	d by		g		9	,		1 □ Ye	s 20 No 3	3 ☐ Prob	ably 4 🗍 Unknown
Ö	w requir s been s should	ete							24a. Was ar	24b. W	ere autor	osy findings available
Be	The lav	Completed							autops: perform	y pr ned2 de	ior to con eath?	npletion of cause of
Vital	iclan: Th certificate rector, pag		25. Was case referred to medical					26. Place of Deat	1 ∐Yes 2		□Yes	2 🗆 No
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0	ng Ph ter th neral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj	jury av. Year)	28b. Time of Injury	28c. Injui Wor	ry at	28d. Describe ho	w injury occurred	a d	
<u>0</u>	endir sath. or: At	atic	2 Accident investiga	ation	-2,,			Yes 2 □ No				
Division of	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of in	ijury - At ho tc. <i>(Specif</i>)	me, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Number , State)	r or Rural	Route Number,
	spital ours a neral L		29a. Certifier 1 Certifying	Physician: To the bes	t of my know	wledge, death	occurred at the ti	me, date and place.	and due to the ca	ause(s) and mar	nner as si	rated.
	To the Hospital or Attending Physician: within 43 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p	Medical		xaminer: On the basis and manner s	of examinat							
	Vithi To ti	Σ	29b. Signature and title of certifie	1/1/1	1		29c. Licens	se number		9d. Date signed	(Month, L	Day, Year)
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	5		30. Name and address of person w	the completed cause of	deam (Item	Coal (Type,)	5 8	attimo	willi	1) 2	12	204
	Sta		31. Date filed (Month, Day, Year)		trar's Signa	ture	1000		7			1
	Registr	ar	AUG 0 6 2	ZUU8	Se Se	AND AND	The state of the s					

Decedent's Name (First, Middle, Last)

Physicia /Medica Examine

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 23e or 28e-f ehow any injury or other treumatic event, the Madical Examinar must be nutified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death

25261

	1. Decedent's Name (First, Middle, Las						Date of Dea Month	th Day	Year	3. Time of De		
ın al		Richard B.	Golden				July	31	2008	6:15 P.	. M	
er	4a. Facility Name (If not institution, give	e street and number)		4b. City, To	wn, or Location	of Death			unty of Death			
	Charlotte Hall V				narlott				. Mary			
	5. Social Security Number 6. S		(In yrs. last birthda)	Months E	ays Hours	Min.	8. Date of Birth (Month, Day	r, Year)	9. Birth	nplace (State or F untry)	Foreign	
	Usual Residence of Decedent		75 115.				08/19/19	944	Mar	yland		
	10a. State 10b. County		10c. City, Town or I	Location						10d. Inside City	Limits	
ō	Maryland Anne	Arunde1	Glen l	Burnie						1 🗀 Yes 2	X No	
rec	10e. Street and Number	iii diidez	01011	10f. Zip Co	ode			10g. Citizen	of What Co	untry?		
To Be Completed by Funeral Director	705 Hamlen Road	1			21061			U.S.A.				
era	11. Marital Status	12. Was Decedent E	ever in U.S. 13	. Was Deceden	t of Hispanic O	rigin? (Spe	ecify Yes or No-	14. 1	Race - Ame			
Ē	1 X Never Married 2 ☐ Married	Armed Forces?	0		Cuban, Mexica		Hican, etc.)		Black, White	e, etc.		
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Viet Nam	1 ☐ Yes 2 🛭	No Specify	y:		Specify: White				
sted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dec	edent's Usual D	Occupation	st of work	ina	16b. Kind o	of Business/I	Industry		
ğ.	Elementary/Secondary (0-12)	College (1-4or 5-	+)	o kind of work of DO NOT use				Bethlehem Steel				
Ç	12th		St	ceel Wo						teel		
Be	17. Father's Name (First, Middle, Last,) Irvin Gold	lon		18. Moti		e (First, Middle,		name)			
J ₀							resa Ocl					
	19a. Informant's Name/Relationship (wn, State, Zip Code)									
	Catherine Copela		Maryland 21061 Location - City or Town, State									
	20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from State	20b. Place of Disposer cometery, cr	ematory or othe	er place)	·	Date	20c. Locati	on - City or	Iown, State		
	4 □ Donation 5 □ Other (Specif		Bayview				4/2008	_Balti	Lmore,	e, Maryland		
	21. Signature of Funeral Service Licer	1500		22. Name and		GU	nce Fun	eral S	Servic	e, P.A.		
	1								∍, Mar	yland 21	225	
	23a/ Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	the death. Do not e e.	nter the mode o	of dying, such a	is cardiac (or respiratory ari	rest,		Approximate Interval Betwe Onset and De	en ath	
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xan	that initiated events resulting in death) Last	cDue to (or as a	consequence of):									
a E												
Completed by Physician/Medical Examiner		d										
χW	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					234	. Date of deli	iven		
clar	in the past 12 months?	1☐Live birth 4☐Pregnant at		Ectopic preg				230.	Month	Day Ye	ar	
ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			,,							
γP	Part II. Other significant conditions of	contributing to death bu	it not resulting in the	underlying cau	se given in Pari	tł.	23e. Did to	bacco use	contribute to	the cause of dea	ath?	
D D	DIABETUS	MELLI	TUS				1 🗆 Y	′es 2⊡nÑ	lo 3 □ Pr	obably 4 Dun	known	
lete							24a. Was	an 2	4b. Were au	topsy findings av	ailable	
Ĕ							autop perfor	sy med?	prior to death?	completion of cau	ise of	
ŏ	25. Was case referred to medical				OC DIA	an of Donat		2 (3 No	1 🗌 Yes	2 No		
To Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpati	ent 3 DOA	0	_	h <i>(Ch</i> eck only o		Dibar (Can	m.6.1		
1	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time		Injury at Work?		28d. Describe h			спу)		
atlo	1 Natural 5 Pending 2 Accident investigatio		Year) Injury	м	Work? 1 ☐ Yes 2 [□No						
100	3 ☐ Suicide 6 ☐ Could not b	286. Place of Inju	iry - At home, farm,	street, factory, o	office				lumber or Ri	ural Route Numbe	a <i>r</i> ,	
Sert	4 Homicide	building, etc	. (эрөсігу)				City or Tow	m, State)				
sal (29a. Certifier 1 Certifying Pt	hysician: To the best of	of my knowledge, de	ath occurred at	the time, date a	and place,	and due to the	cause(s) and	d manner as	stated.		
Medical Certification:	one) 2 Madical Exam	miner: Dn the basis of and manner sta	examination and/or	investigation, in	my opinion, de	ath occur	red at the time, o	date and pla	ice, and due	to the cause(s)		
≤	29b. Signature and title of certifier			200 1	icense number	,		29d Date si	igned /Mont	to Day Vessel		

certificate hes been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 芶 To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours efter death. To the Funeral Director: A

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG

State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA

DHMH 17 Rev 1/2001

Examiner o Division of Vital

attending physician and for use as the burial-transit cate has been signed by the page 2 should be detached certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Exami Physician/Medical 2 Completed Be Certification: To

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, Ine Medical Examinat must be rotified at once.

Physician /Medical

altimore, Maryland 21215-0036

/Medical

MD

Director

Funeral

2

Completed

Be

10

State Registrar

Medical

29b. Signature and title of certifier ohit Jour

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

20 966

2008 AUGUST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIAL 31. Date filed (Month, Day, Year)

AUG 0 6

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined

2008

and manner stated.

900 CATON
32 Registrar's Signature

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene 25263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Matilde Guzmar **Physician** 2008 5:13 Aug. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 406 Enfield Rd. Harford Joppa If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs 03/29/1922 Guatemala Director 213-58-0167 86 Usual Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Harford Director Joppa 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 406 Enfield Rd. 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 XYes 2□ No Spaniard Be Completed by Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dancer Entertainment 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Luis Navarro Sola Felisa Galinier Valero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatriz O'Brien/Daughter 151 Keswick Dr. Advance, N.C. 27006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A 21. Signature of Funeral Service Licensee M01443 Retter 8717 Green Pastures Dr. Towson, MD 21286 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wronumartendisease disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria the death certificate be Physician/Medical 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No performed' 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury investigation To the Hospital or Attend within 24 hours after death. To the Funeral Director 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058878 August 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belcamp MO 21017 1321 Riverside Suite way 31. Date filed (Month, Day, AUG 32 Registrar's Signatule Vear) State 2008 Registra

08-05955 James Alan Graf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25264

mes Alan O		R	For State or War yrand	Certificate	of Death			Reg	. No.				
Physic		1	Decedent's Name (First, Middle,Last) James Alan Graf					2. Date of Death Month August 3, 2	Day Year	3. Time of Death 2327 hrs			
al Exar	mire	_	a. Facility Name (if not institution, give street and number		4b. City, Tow	n, or Loca	ation of Deat		4c. County of De	ath			
			9633 Hingston Downs		Columb				Howard	Digital page (Chate as			
Funera				e (In yrs. last birthday) If Under 1 Months		f Under 24Hi Hours Mi			Birmplace (State or reign Country)Illinois			
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Maryl	fied at once.	Ulrector	0e. Street and Number 9633 Hingston Downs		10f. Zip Co	046		10	U.S.A.	ountry?			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she	= 1 '	_ L	Marital Status 12. Was Deceden	Ever in U.S. 13.	. Was Decedent	of Hispan		Specify Yes or No-	14. Race - An	nerican Indian, Black,			
death w	nust be	Fune	1 Never Married 2 Married Armed Forces	No	If Yes, specify (to Rican, etc.)	White, etc				
after o		<u></u>	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X			work done	Specify: W 16b. Kind of Busine	hite ss/Industry			
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036 thin 72 ne.	the Medical	Completed	12		ems Ana	_				f Defense			
215-0036 be filed within 7 ntal Hygiene. rked other than	the M		17. Father's Name (First, Middle, Last) Frank E. Graf, Jr.					ne (First, Middle, M Ransone	aiden Surname)				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other th	other traumatic event,	o Be	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address				per, City or Town, S	tate, Zip Code)			
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hysicia	an	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austriagn Funeral Home at MMP. I Austriagn Funeral Home A										
Medic ∉xamin	_		Immediate Cause (Final disease a. Atherosclerotic	Cardiovascular	Disease					Death			
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876 rtificate	as the		23b. Was decedent pregnant in the	2	Fetal death	3	Ectopic pre	gnancy	Month	Day Year			
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D. B It the d	ached		Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying	ause give	en in Part I.			te to the cause of death?			
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Divis Hospital or A 24 hours after Funeral Dire	ly filled in		29a. Certifier	my knowledge death	occurred at the	time, date	e and place.	and due to the caus	se(s) and manner as	s stated.			
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The Purposition of the this certificate has been signed by the attending physicial	completely	Medical	one) Certifying Physician. To the best of each manner state	kamination and/or inve	estigation, in my	opinion, d	death occurr	ed at the time, date	and place, and due	to the cause(s)			
1	8	₹	29b. Signature and title of certifier		290	License				(Month, Day, Year)			
			Mlen Grasself, ME			O.C.M	I.E.		August 4, 20				
13			30. Name and address of person who completed cause of Melissa Brassell, MD Assistant Medic	f death (Item 23a) al Examiner 1	11 Penn Str	eet, Ba	altimore, N	/ID 21201					
		ate	#		north .								
	St		31. Date filed (Manth, Day, Yeer) 2008	10 30 Page	The way								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 200 /Medical lity Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Prince pita rever 8. Date of Birth (Month, Day, Year) ge (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months Min Hours 1 M 2 □ F Director ct. 20. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 28a-f show notified 1 XYes 2 No Director CL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be r USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation or other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnal Be 2 tarrison aro umas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AFO, AP Brother USAGI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Termation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State reate 22. Name and Address of Facility 21. Signature of Funeral Service Licensee "Street N.W. complications that caused the death. Do not enter the mode of dying, such as cardiae or respirator arrest, st only one cause on each line. Approximate Interval Between Onset and Death 23a and Enjer the disease shock, or heart failure. Immediate Cause (Final **Physician** Acquired immuned 3 V/S. /Medical resulting in death) Due to (or as a consequence) () **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No . 24a. Was an has certificate 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 1 Inpatient 2 ER/Outpatient 3□ DOA s after death, al Director: After ti 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manne of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: completely filled in by the funeral director, within 24 hours a To the Funeral D

29b. Signature and (it)e of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS n who completed cause of death (Item 23a) (Type, Print) MU MO 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

and manner stated

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State of Maryland / Department of Health and Mental Hygiene

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with 1	3a or		10e. Street and Number 7502 Lairds Way			10f. Zip Code	.029		10g. Citizen of Wha	at Country?
death	ems 2	Funeral		12. Was Decedent Ever i	in U.S. 13.		Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		American Indian, White, etc.
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		y s	25a Part 1. Enter the dicease, or complishock, or heart failure. List only or Immediate Cause Final	cations that caused the cause on each line.	death. Do not en	(or respiratory arr	rest,	Approximate Interval Between Onset and Death
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BOX leath ce	aftend for us	Physician/M	in the past 12 months?	3c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	•
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hysici	his ce I direc	To B	examiner? 1 ☐ Yes 2 X No	lospital: Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth	or:	· · · · · · · · · · · · · · · · · · ·	ence 6 Other	(Specify)
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DIVISION OF VICAL To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of examined manner stated.	knowledge, deat mination and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	e, and due to the durred at the time, o	cause(s) and manr date and place, and	ner as stated. I due to the cause(s)
Fo the	To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	29d. Date signed (/	Month, Day, Year)
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10			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	altimore	MAT	1201	
	Sta	te	31. Date filed (Month, Day, Year) 201	32 Registrar's S		and i	WII WINE	1114 2	1 40	
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State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Robert D. Holler AUGUST 2002 1418 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Year | If Under 24 Hrs Agnes Hospita 8. Date of Birth
(Month, Day, Year)
July 26, 1 If Under 1 Year 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday **Funeral** Hours Days Months 1 🖾 M 2 🗆 F 212-20-8752 1923 85 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanimer must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21228 USA 719 Maiden Choice Lane BRT35 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ⊠Yes 2 No
If Yes, Give
Year or Dates: 1943-45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Defense Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph P. Holler Lucy Kibler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moss View Court; Catonsville, MD 21228 Donald Holler Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD Lake View Mem. Park 8/7/2008 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lige 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 3 6 14 w/5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFARCTION **Physician** MYOCARDIAL /Medical Due to (or as a consequence of): Examiner 20 HYPERTENSION Jems if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for t Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes _2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2□No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number CURM 22255 August/03/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+ AVE, BALTIMORE, MD MHD NAWRAS CUROI 200 CATON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 200 gar **Physician** 11:56р м Margaret Μ. Hamilton /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Timonium Stella Maris Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 ☐ M 2 ☐ XF 155-12-9444 86 1922 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State ms 23a or 28a-f sho Director 1 ☐ Yes 2√☐ No Baltimore Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21234 USA 2213 H. Lowells Glen Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ?? is marked other than "natural", or items traumatic event, the Medical Examinating 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Specify White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Julia Whalen Gerald Maloney ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Weatherfield Dr. New Freedom, Pa. 17349 of Health item 27 is Mr. Robert P. Hamilton/ Son permit. Pages 1 and :
Department of Heath
Important: If item 27
any injury or other tr.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-8-08 Bel Air, Md. Bel Air Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Equity Funeral Home, 21. Signatur of Fundral Service Ligens e 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **K** No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 K No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature as 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 2008 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUU Registrar

AUGUST

MARGARET HAMILTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** P^{M} 1:37 CAROL ANN HENSLEY JULY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAROLINE DENION CAROLINE HOSPICE CENIER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🔀 F SEPT. 10, 1960 Director 213-72-0612 47 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Cify Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director MDCARCLINE RIDGELY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 206 ORIGLE AVE 21660 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 ☐ Married Maryland 21215-0036 9 1 ☐ Yes 2 ☑ No Specify Specify: WHITE If Yes, Give Year or Dates: \$ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 Is marked other the **7IH** CASHIER GAS & OIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic e ပ LAURA SPARKS HOLT HENSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2027 PAULETTE RD. - APT. #1, DUNDALK, MD 21222 DELORES CROMER/FRIEND 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/26/2008 HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Servige Licenses 2007-09 EASIERN AVE., BALITMORE, MD 21231 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 ☐ Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute whe cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ⋧ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 2 🗆 No 1 ☐Yes 2 No Division of Vital 25. Was case referred to examiner? medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 6 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:03PM 3,2008 E . August Robert Jones Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 🔀 M 2 🗆 F Virginia 63 Dec.18,1944 226-56-8951 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. The triems 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modified Extra direct must be notified as Takoma Park 1 ☐ Yes 2 ☐ XNo Md Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20912 USA 7301 Hilton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 □ Yes 2 ☑ No If Yes, Give Year or Dates Specify: Specify: Black ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fence Installer Fencing Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pear1 Pierce Robert E . Jones Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) d. Pages 1 and and and on the office of the 7301 Hilton Ave. Takoma Park, Maryland 20912 Paulette Jones -Wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Grove Cem. 8/9/08 Williamsburg, Va. 4 ☐ Donation 5 ☐ Other (Specify) 7345 Pocahontas Trail 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Whiting Funeral Home Williamsburg, Vaiss 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) W Muh /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Bockenater Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Cal (Check only and manner stated 29b. Signature and title of certifier 29c. License number D18895 August 4, 2008 AVE/STE340, TAKEMA PARK, MD 20912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

7010 CARROLL

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ICATZIM,

MUBARAIL 31. Date filed (Month, Day,

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MATTIE **JAMES** August 10-30AM 2008 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL BA I timore timore City If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛣 Months 09/24/1952 MD 215-60-2968 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5525 BELLEVILLE AVENUE 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ▼ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** 5+ **EDUCATOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHNNIE PRESTON FAIRCLOTH ROSA MAE MCRAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ROSA M. FAIRCLOTH/MOTHER 915 APPLETON ST. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL PK. 08/11/2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 mes 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRAtion Preumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩o 24a. Was an autopsy performed? /es 2 \textsquare 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any liviny or other traumatic event once.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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21215-0036

Baltimore, Maryland

tient

X

MATTIE

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examiner

physician and s the burial-transit certificate this After i

Be

2

Certification:

Medical

Physician/Medical þ Completed

27. Manner of Death
1 XNatural
2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Hospital:

1 🔲 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 □ DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of centific hysiciAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D0054558 29d. Date signed (Month, Day, Year)

ERTIK 31. Date filed (Month, Day, Year)

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5 Pending investigation

6 ☐ Could not be

determined

BURKE JR, MD SINAI 32. Registrar's Signature

State Registrar

within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 199 per land \$82 8-6-08 f Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:01 A M 2008 KAMALUDIN AUGUS T FIDUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 065-90-5215 51 57 Director 05 01 Guyana Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov notified at 1 ☐ Yes 2 🔀 No Director Middle River Baltimore MD with the 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ò r than "natural", or items 23a o U.S.A. 21220 2222 Firethorn Road Funeral . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 2 should be filed within 72 hours a and Mental Hygiene.

is marked other than "natural", c 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Chesapeake Spice Co. Machinist ňa 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salma Kamaludin Jakey Kamaludin Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sumintra Ramcharran-Kamaludin Firethorn Road, Middle River, Md 21220 item 27 <u> 2222</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If it any Injury or o once. Woodlawn, Md King Memorial Park 8/2/08 21. Signature of Funeral Service Licenses March F/H West 21215 4300 Wabash Ave, Baltimore, tyrette 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONE WEEF HYPOXIA /Medical Due to (or as a consequence of) Examiner ONE MON TH BRONCHOINEUMONIA OFGANIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the att 2 🗍 No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown been sig should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has by lirector, page 2 s autons 2 X No 2 No 1 Yes 1 X Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 MInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🔀 Natural M 1 ☐ Yes 2 ☐ No death. 2 Accident Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

EDWIN OSTRIN MD. PHD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 0 6

MOIPHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

AUGUST 1, 2008

(check only one)

29b. Signature and title of certifier

sente?

2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RBS - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mai	ylallu / L	Certific				g. No.2 ()	08	2527	13
	Physicia	n	1. Decedent's Name (First, Middle, Las	t)		-OTT	_		2. Date of Death Month	Day	Year	3. Time of Deat	th M
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)				ocation of Death	97	4c. County	of Death	[[17]	
)	Examin	er	Tate Hospice Ho				inthic				Arun	de1	
j2-	Funeral		5 Social Security Number 6 S	ex 7 Age	(In yrs. last bir		der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or For	reign
	Director		213-34-7001	□ M 2 X F	59	Yrs.	ls Days	Tiodis Will.	Apr 8,	1949	Penn	sylvania	ı
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Lir	mits
	Maryla f sho led at	ō	MD Anne Aru	ndel	Glen	Burnie						1 □ Yes 2▼]No
	r 28a- notif	Director	10e. Street and Number			10f.	Zip Code		10	g. Citizen of	What Cour	itry?	
	th with	a D	927 Princeton Te	rrace			21	1060		USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was De If Yes, s	cedent of His specify Cuban	panic Origin? (Spe i, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,		
215-0036	be filed within 72 hours after death with the Maryland Hyglene. 4d other than "natural", or items 23a or 28a-f show ad other than "matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 📉 No If Yes, Give Year or Dates:				Specify:		Specia	_{fy:} whi	te	
ر ک	72 hc 'natur	etec	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a	. Decedent's U	Isual Occupat work done du	tion uring most of worki	ing	16b. Kind of E	Business/In	dustry un	ık
12	within sne. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	office							
7 0	filed v Hygie ther t		17. Father's Name (First, Middle, Last)			JITICE		18. Mother's Name	(First, Middle, N	faiden Surna	me)		
a	ould be filed v I Mental Hygie narked other t natic event, th	To Be	Eugene Victor We	tzel				Laurett	a Elizab	eth Ke	ssler	•	
<u></u>	R D I I		19a. Informant's Name/Relationship (Type. Print)	195	o. Mailing Addı	ess (Street ar	nd Number or Rura	al Route Number,	City or Town	, State, Zip	Code)	
	and 2 ealth a n 27 is		Gil W. Lott/spous	se				Terrace				21060	
Baltimore,	Pages 1 nent of Hi int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specification)	Removal from State	20b. Place o cemete	of Disposition (ery, crematory	Name of or other place		Date	20c. Location	- City or To	own, State	
Balti	permit. Pages Department of Important: If it any Injury or o once,		21. Signature of Euneral Struce Licer Rona		ctor			of Facility My Board		Baltin	nore S	treet	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused t	he death. Do	not enter the	more, node of dying	MD 2120 , such as cardiac	Tor respiratory arre	est,	- 1	Approximate Interval Between	
	Physician		Immediate Charle (Final	one cause on each line	nle		lona				- 19	Onset and Deat	h
7	/Medical		disease or condition resulting in death)	a. Due to (or as a	crisequence								
	Examiner		Sequentially list conditions	b		_							
100	pe tis	iner	Sequentially list conditions, if any feeding unintered to cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):							
	and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):							
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O. Box	The law requires that the death certi tte has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal deatl	h 3⊟Ectop 5⊟ Other	ic pregnancy (specify)				ate of deliv Ionth	ery Day Year	
٦.	that the bad by detac		Part II. Other significant conditions of	ontributing to death but	not resulting i	in the underlyi	ng cause give	n in Part I.	23e. Did to	pacco use cor	ntribute to t	he cause of death	1?
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II II		Be C	25. Was case referred to medical					26. Place of Deat		¥	1-2-1-5 (**	-	
- >	Physiclan: The lav this certificate has ral director, page 2	ToE	examiner? 1 ☐ Yes 2 € No	Hospital: 1 Inpatien		utpatient 3		4 LI Nursing Fig	ome 5 🗆 Reside		ther (Speci	by Hospice	- /the
ב ס	Ing P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury Work		28d. Describe ho	ow injury occu	urred		
<u>s</u>	ttend death. stor: /	icati	2 Accident investigation 3 Suicide 6 Could not b	9 28a Place of injur	y - At home fa	Arm street fa		/es 2□No	28f Location (St	treet and Nun	ober or Rur	al Route Number,	
Division or	i or Attending P after death. Director: After t d in by the funera	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	am, sacci, ia	otory, office		City or Town	n, State)	ibei oi riui	arriodie riamber,	'
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C		nysician: To the best of miner: On the basis of and manner state	examination a								
	To the within Fo the comple	Me	29b. Signature and title of certifier	0			29c. License		2	9d. Date sign			
}			James Ja	to suita i	m		D	21438		July,	29,	2008	
			30. Name and address of person who	Appleted cause of de	ath (Item 23a)	(Type, Print)	3/5	H & Heal	An Anda	JAPINES	Mo	2008	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	UCI	تان عال	1 10111001	, 1 1 1 1 1 1 1	-/	1		
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene \(\chi \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lamdin G. Jose August 4, 2008 6:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Commons Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 10/23/1915 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2X1 F Director 214-38-1744 92 England Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County natural", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director n/a Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 USA 301 W. Lafayette Avenue Funeral . Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Fashion Merchandising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Greenhalgh Jane Livesey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 W. Lafayette Avenue Baltimore, MD Department of Health Important: If item 27 Mr. Denis J. Lamdin / Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 X Cremation 3 ☐ Removal from State **BayviewCrematory** 8/6/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, MD 21229 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Wiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 **3** No 2 No 1□ Yes 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Peath (Check only one) examiner? Other: 1 Yes 200 1 | Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. ove 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erederick Rd. Coforpile, MD 21228 31. Date filed (Month, Day, State 06 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of Ma	aryland		artment of H			gienę́ Reg. No.		252	15
			Decedent's Name (First, Midd	le, Last)						2. Date of De	ath		3. Time of De	eath
	Physic /Medi		Gerald LaSal	Le						July 2	1, Day	2008 Year	6:15 PM	1 M
)	Exami		4a. Facility Name (If not institution					4b. City, Town, or	Location of Death	1	4c.	County of Dea	th	
			16532 Walnut					Gaither				Montgo	,	
	Funeral Director		5. Social Security Numberunk		M 2□ F	ө (In yrs. las 75	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 22	h Y, Year)	932 9. Bir	thplace (State or Fountry)	oreign 1K
	D >		Usual Residence of Decedent 10a. State 10b. Count			100 City 1	T! .						T404 1-14- 01-1	1.1
	ehov	5			2017	10c. City,							10d. Inside City I	
	281	ect	MD Mont	-gome	ггу	Gal	Luer	Sburg 10f. Zip Code			10a Citi	izen of What Co		
	23a or	Funeral Director	16532 Walnut	Hil:	Drive			10.1 2.10 0000	20878			USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantal Hyglene. Important: if item 27 ie marked other than "naturei", or items 23e or 28e-f ehow important: if item 27 ie marked other than "naturei", or items 23e or 28e-f ehow applicant: if item 27 ie marked other traumatic event, the Madical Eventing must be notified at ance.		11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 至 Divorce	rried	2. Was Decedent Armed Forces? 1 M Yes 2 1 If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba l □ Yes 2∏ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	oecify Yes or No o Rican, etc.)		14. Race - Ame Black, White Specify: 7		
21215-0036	within 72 h ine. ihan "natu e Medicel	Completed by	15. Decede (Specify only highe Elementary/Secondary (0-12)	st grade	Completed) College (1-4or 5		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of won	_{king} unk	16b. Ki	ind of Business	/Industry	unk
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Maryland	and 2 should seith and Men n 27 le marke ler traumatic	2	19a. Informant's Name/Relation Montgomery Co				19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	ar, City o	r Town, State,	Zip Code)	unk
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🔯 Other (cem	e of Disponentary, cren	sition (Name of natory or other plac		Date	20c. Lo	ocation - City or	Town, State	
Balt	permit. Departn Imports eny inju		21. Signature of Funeral Service Ronald	S. W	ade Tr	egypt	1	Name and Addres	tomy Boar		. Ba	ltimore	Street	
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8760,	icate be executed physicien and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	{	Due to (or as	a consequer	ART	ery Di	SEASE					
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/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	al _					26. Place of Dea	th (Check only o	ne)			
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Division	al or Atte s after de i Directo id in by th	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be nined	28e. Place of Injuding, et	ury - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or R	lural Route Numbe	r,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edicai (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Phys Examin	ician: To the best er: On the basis of and manner sta	f examination	edge, death n and/or in	occurred at the tin restigation, in my of	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certific	Tr	AM.	D		29c. License	number		29d. Dat	te signed (Mon		
			30. Name and address of person	who co	GRAF	17.	1)							
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DHMH 17 Rev 1/2001

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ert Langston		For State Certificate of Death	Reg	
Physician edical Examine	/ 1	Decedent's Name (First, Middle,Last) Robert Earl Langston, Sr.	Date of Death Month [July 30, 200	3. Time of Death Oay Year 0915 hrs
A Examine		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
		Harbor Hospital Social Security Mumber 16 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs.	Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	5	Months Days Hours Min.		Foreign 29, 1965 Country) MD
any	_	Isual Residence of Decedent 10c. City, Town or Location 10c. City 10c.		10d. Inside City Limits
* .	-	MD ANNE ARUNDEL BROOKLYN PARK		1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, and the filed within 72 hours after death and Mental Hygiene, and the filem 27 is marked other than "natural", or items 23a or 28a-7 show a net. If item 27 is marked other than "mature must be notified at once.	Director	0e. Street and Number 10f. Zip Code	109	g. Citizen of What Country?
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leath w	ᇒᅵ	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	tican, etc.)	White, etc.
safter de	교	Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	ork done	Specify: WHITE 16b. Kind of Business/Industry
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired for the complete of the control of the complete of the comp	ed)	
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re	ural Route Num	ber, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is		WILLIAM C. LANGSTON, JR 1602 FOUR GEORGES CT	- APT	T-1, DUNDALK, MD 20c. Location - City or Town, State
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cau at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
To To Com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		Journal Journal O.C.M.E. 30. Name and address of person who commeted cause of death (Item 23a)		July 31, 2008
OF Pents	V2 Y	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201	
St Regis	tate			

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			For State	State of Mar	yland		rtment of l			lental Hy		711115	3 25	5277
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cer		Deain		2. Date of De	Reg. No.			e of Death
	Physicia /Medic		David Eugene Mi	ŕ					i	Augu:	i Da	200	1 2	25 M
	Examin		4a. Facility Name (If not institution, gi	,			4b. City, Town,	or Location	of Death)		County of De		
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	Funeral Director			4 DY 14 0 D =	54	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D Nov. 8	ay, Year) 19	1 (ountry) braska	ite or Foreign 1
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	the N	Director	Maryland Prince 10e. Street and Number	George's	COTTE	ege Pa	10f. Zip Code				10g. Cit	izen of What C	Country?	
	h with	al D	6305 Pontiac Str	eet			20740				USA			
	ems	uner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	/as Decedent of I Yes, specify Cub	Hispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh		٦,
7	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if them 27 is marked other then "natural", or items 23a or 28a-f show eny Injury or other treumetic event, the Madical Evaluinar in 1st be inclified at once.	Be Completed by Funeral	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □XNo If Yes, Give Year or Dates:			□Yes 2XNo	Specify				Specify:		
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$M_I/b_{\mathcal{O}}$	Peges 1 nent of He ent: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 [Removal from State	20b. Plac	ce of Dispos	ition (Name of atory or other pla 1C	ce)	C	ate	20c. Lo	cation - City o	r Town, State	9
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פיי	Ing P	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day, Y	(ear) 2	8b. Time of Injury	28c. Inju Wor		- 1	28d. Describe	how injur	y occurred		
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	tospin t hours unera ely fille		(Check only 2 Medicel Exa	hysician: To the best of r miner: On the basis of ex	ny knowle	edge, death	occurred at the ti	me, date a	ind place,	and due to the	cause(s)	and manner	as stated.	se(s)
	or the hospital or Attending Physicien : The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 29b. Signature and title of certifier	and manner state	d.		29c. Licens					te signed (Mor		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year AM 1c, Kenne 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner 1emoria ore 7. Ale (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Comptry) 6. Sex **Funeral** Year) Months Days Hours Min 1 M 2 M Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evantment ust be notified at once. 10h County 10c. City, Town or Location 1XYes 2 □ No **Funeral Director** 1201+1More 10e. Street and Num 10g. Citizen of What Country 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: ģ Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12))6 mestic 17. Father's Name (First, Middle, Last) Be unknown ပ ne/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atonsville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility Greene Funeral Services 21229 talto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Leccure disease or condition resulting in death) unknown /Medical Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed on chronic physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as been signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy page performe 2 NNo 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Begistrar's Signature

Ka

AUG 0 6

ahmy 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** WALTER MIDDLETON AUGUST 3, 2008 6:00 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13706 SCOFIELD ROAD, N.E. FLINTSTONE ALLEGANY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**⅓**M 2□ F Days Months Hours Min 76 04-12-1932 Director 225-38-0744 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2√ No Director MD Allegany Flintstone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13706 Scofield Road, N.E. 21530 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married "natural", or if edical Exa<u>mln</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. ₽ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Fence Company is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Middleton Mossie Lee Phipps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other travonce. Carolyn Middleton- wife 13706 Scofield Road, N.E., Flintstone, MD 21530 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1K Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Epis. Ch. Cem. Elkridge, Maryland 8,2008 M00053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of ineral Service License MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Ent a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YVS **Physician** anci ea /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2/21/10 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy performed? Yes 22 No death? 1 Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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30 W 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001 mile

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month 7:06 P M Gerald Morgan 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mayland Medical Center thmore Social Security Jumber 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Year Director 212-44-5027 North Carolina 64 16,1944 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 4 Ballycruy Court, Unit 201 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🚺 No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, I a. once. U.S. Government Cartographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calloway ည Guv Μ. Morgan Dorothy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Ballycruy Court, Unit 201 Timonium, Maryland 21093 Colleen R. Morgan 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Mem. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-5-2008 Timonium Maryland Gardens 21. S 90 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Demyelinatino disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner umania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or): Lenal The law requires that the death certificate be executed Failure burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown ģ signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 Nes 2 □ No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital

after death. filled in by the within 24 hours a completely

State

29a. Certifier

(Check only one)

29b. Signature and title of cer

31. Date filed (Month, Day,

Medical

South Green

and manner stated

22

32. Registrar's Signature

Malia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sherr, MD Month, Day, Year)

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

18176

Street Bathmore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

Amend: item 8 per F.H reb Certificate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sa e99 2008 Son In ug. /Medical 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner Se Social Security 7. Age (In yr If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Jan. **Funeral** Min. 1□M 2⊠F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantimer must be notified at 1 Nes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 Widowed 4 Divorced Blac Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) leaning Vor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Important: If Item 27 I M d. 21229 4 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ↑ Burial 2 ☐ Cremation 3 Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) to. permit. 22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 12222 W. North Ave. Bauto. Md. 21 21. Signajure of Funeral Service Licenses 23a. Part 1 Enter the thease, or complications that cause 1 the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MAU disease or condition resulting in death) Cana /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar n S θη Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 I Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records 2 n by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 □ No Division of Vital 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 6-DiOther (Specify) Arrer this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1. ₩atural Injury death. 1 □Yes 2 □ No 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Place Armore 31. Date filed (Month, Day, Year) Registrar's Signature State AUG Registrar

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amend items 20b,c per fh g882 8-21-08 vt

State of Maryland / Department of Health and Mental Hygiene

1- For Amend 19a, per FH G882 8/8/08 TT

Certificate of Descriptions Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August sbor TIONZ 6:40 A M 4, 2008 /Medical Eacility Name (If not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** limonium (In yrs. last birthday)
4 2 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** 218-44-3100 1**X** M 2□ F Months Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinar must be nutified at any Injury or other traumatic event, Item Medical Examinar must be nutified at once. MD timore 1 Yes 2 No Director 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21239 USA eridene Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>}</u> Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) should be filed withi and Mental Hygiene. Gias Attendant XXon Cashier 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be DOVA ၉ homas 19b. Mailing Address (Street and Number of 815 Braeside R ral Route Number, City or Town, State, Zip Code) Relationship (Type. Pant) 99Nichote 815 Pages 1 and 2 tment of Health atonsville, CM 20b. Place of Disposition (Name of woodlawn or other place 20c. Location - City or Town, State

Baltinore 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12.08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee tile 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner avoral N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusity (or as a consequence of). burial-transi Due to (or as a consequence of): physician sthe burial P.O. Box 68760, certificate be Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ ★ 0 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has b irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HOSPICE Hospital: After this c funeral dire 1 ∐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation hours after death, 1 ☐ Yes 2 ☐ No I Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled in within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) 8/19/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.

32. Signature EDDIE NAKHUDA TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 2008 AUG 0 6 Registrar

2008

AUGUST

ALONZO OSBORN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:10 A^M Ornella Marina Oldfield 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner 1217 McCurley Avenue Baltimore Catonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 530-78-5260 62 March 10, 1946 Italv Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter of Health and Mental Hygiene. Inter If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1217 McCurley Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Was Decedent EV Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luigi Fenos Carmela Matiz ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Richard A. Oldfield Husband 1217 McCurley Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If its any Injury or o once. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 8/12/2008 Owings Mills, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensi 1401490 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician endometria Cancel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of). ending physician a use as the burial-Box 68760. Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? P Month Year 5 Other (specify) P.0. the 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 □Yes 227 No certificate 2 □ No 1 ☐ Yes To the Hospital or Attending Physician: director Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural investigation 1 □Yes 2 □No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 900 ton aux role 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 6 2008 Registrar

			For	State of Marylan	d / Depa	artment	of He	ealth a	nd Me	ntal Hyg	giene	9	
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Physician /Medical		disease or condition resulting in death)	on	Pa. Due to (or as	a conseq	uence of	11C2	5	Non S	mall	· a	11	-	3403
Examiner		Soquentially list on	anditions	b										
ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Due to (or as	a conseq	uence of):							
executed n and ial-transit	хап	Cause (Disease or that initiated event resulting in death)	s Last	c Due to (or as	a conseq	uence of):							
be cia				d.										
tificat ng phy as the	ledi													
eath cert attendin for use	an/N	IF FEMALE: 23b. Was deceder		23c. If yes, outcome 1 ☐ Live birth			3 ☐ Ectopic	pregnanc	cv			23d. Date of		
the at	Physician/Medical	in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	No	4 ☐ Pregnant a 9 ☐ Unknown	at time of o	death	5 Other		·		-	Month	1 L)ay Year
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the I				s contributing to death b	out not res	ulting in t	the underlying	cause giv	ven in Part I.	23e. Die	d tobacco	use contribu	ute to the	cause of death?
quires n sign ald be	d by									1 2	Yes	2 □ No 3	☐ Proba	bly 4 ☐ Unknown
aw requir as been si 2 should I	olete									24a. Wa		24b. We	re autops	sy findings available
The Is	Completed									au pe 1 □ Yes	topsy rformed? 2.4	dea	ath?	pletion of cause of 2 □ No
	Be C	25. Was case referexaminer?	rred to medical						26. Place of Dea				1100 -	
hysle this o	ဥ	1 Yes 2 €					patient 3 🗆	DUA		lome 5			(Specify))
. 60 9 9	ion:	27. Manner of Dea 1. Natural	tn 5 ☐ Pending investiga	28a. Date of Inj (Month, Da	ury a <i>y, Year)</i>	28b. Tii Inj	me of ury M	28c. Inju Wor	ryat rk?]Yes 2 □ No	28d. Describ	e how inj	ury occurred		
Atten deatl ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could no	ot be 28e. Place of In	jury - At he	ome, farn			1163 2 1140	28f. Location	(Street	and Number	or Rural	Route Number,
al or a after al Direction bed in b	Certification:	4 ☐ Homicide	determin	building, e	tc. (Speci	fy)				City or 7	own, Sta	ite)		
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur.	edical (29a. Certifier (Check only	1 ☐ Certifying 2 ☐ Medical E	Physician: To the best xaminer: On the basis	of examina	owledge, ation and	death occurr /or investigati	ed at the to	ime, date and plac	e, and due to t urred at the tim	he cause ie, date a	(s) and manr	ner as sta	ated. the cause(s)
thin 2 the l	Med	one) 29b. Signature and	title of certifier	and manner s	tated.		2	9c. Licens	se number		29d. [Date signed (i	Month. D	lav. Year)
F % F 8			100	11										
/ /				ho completed cause of	death (Iter	n 23a) (T	ype, Print)	.,	Catus		* **	J		
le		9 -	eds IV	ms 112	201	1-RC	Edille	Rd	Catus	ville 1	no	212	28	
Sta Registr		31. Date filed (Mor	nth, Day, Year)]G 0-6 2	008 82. Regist	rar's Sign	nure	reser							
- Inegioti	-	Fil	200 2 2 2											

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25287 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death "Day... **Physician** MUGUST 2008 6:45 PM Perella. Teresa Marie /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Pennsylvania 8. Date of Birth (Month, Day, Year) April 25, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1 □ M 2 1 F Hours Director 162-10-3763 89 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits directinust be notified at 1 ☐ Yes 2 💢 No Funeral Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 U.S.A. 201 Meadowvale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 o Specify. other traumatic event, the Medical Exa-Be Completed by 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Library Administrator Goucher College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morris ပ္ Joseph Denning Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth ar Important: If Item 27 is any injury or other trauonce. 201 Meadowvale Road Lutherville, Maryland 21093 Kathleen M. Rusen Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-7-2008 Timonium Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and reley filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Momicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a.M. wellis. R. 08/02/2008 train D 36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 TOWSON, MARYLAND 21204 M. D., OSLER DRIVE. STUART R. WII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

of Vital Records,

Division

CONSALA

State of Maryland / Department of Health and Mental Hygie Certificate of Death

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J. No.	_	_	_	-	_	_	_	

Physiciar /Medica Examine
Funeral

Director

"natural", or items 23a or 28a-f show diral Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

be executed been signed by the attending physician and should be detached for use as the burial-tran page 2 s To the Hospital or Attending Physician: funeral After ours after death.

neral Director: Af
filled in by the fur

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month August 5, 0214 М Juana Juanita Rodriguez 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/13/1949 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 = F Puerto Rico 583-40-8213 58 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland | Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10405-A 46th Avenue Apt. 201 20705 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rlack. White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:Puerto 1 Yes 2 □ No Specify: Hispanic Completed by 3 ☐ Widowed 4 ☑ Divorced Rican 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Specialist Federal Agency 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andres Lugo Dominga Duprey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1704 Seward Avenue Apt. 3C Bronx, New York 10473 Jose Lugo - Brother 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Municipal Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08/11/2008 Arroyo, Puerto Rico 4 ☐ Donation 5 ☐ Other (Specify) of Arroyo 21. Signature of Funeral Service Licensee David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Nart1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Myocardial Infarction disease or condition resulting in death) Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2X ER/Outpatient 3 □ DOA 1 ☐ Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 XNatural 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22966 30. Name and address of person who completed cause of death tem 23a) (Type, Print) 7300 Van Dusen Road Laurel, MD 20707 Thomas H. Burquieres MD Laurel Regional Hospital, Emergency Dept 31. Date filed (Month, Pay, 32 Registrar's Signature State 2008

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No 2008 25289 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August **Physician** 2008 6:10 PM Katheleen Remencus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 390 Stanford Court Arnold 8. Date of Birth (Month, Day, Year) Anne Arundel 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 KF 332-18-4234 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 Is marked other then "natural", or items 23e or 28a-f show traumatic event, the Madical Exertifier must be notified at 1 □Yes 2 🗖 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 390 Stanford Court 21012 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental George Morris Gejokos Ernestine Parrish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is eny Injury or other trau Brooks Remencus (Son) 390 Stanford Court Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8-5-2008 Glen Burnie, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP 21. Signature of Funeral Service Licensee ma050 L. Kaulman Funeral Home at MMP, Inc. Washington Blvd Elkridge, MD 21075 7250 23a. Part 1. Enter 😡 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Za_ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician. The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical phys the b attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year P.O. I 1 □Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ج</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2-1No 1 Yes of Vital 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only ope) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funel completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in3 406 31. Date filed (Month, Day, 2. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 25290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 3:15 RUSSELL eleanor AUGUST 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-15-1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 24 □ F Maine 70 Director 219-26-8707 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprinter mast be notified at 1 ☐ Yes 2√F No Director Baltimore Dundalk death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 213 Colgate Avenue 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Experi 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: \$ 3 Widowed 4X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon W. Rix Emily L. Johnson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda Gephardt - Daughter 105 Highshire Court, Dundalk, Maryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 7, 2008 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 MMP, Inc., 7250 wash. Blvd. Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BACTEREMIA GRAM NEGATIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ASPIRATION PNEUMONIA The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for us 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2 No Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s autopsy performed' certificate 1 ☐Yes 2 ☐No 1 Dies 2 No Physician: 25. Was case referred to medical example? Be 26. Place of Death (Check only one) 1. Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ۴ 1 Inpatient this al or Attending Phy s after death. I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number AUGUST 4, 2008 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 EMMANUEL GORDSPE, MD/JOHNS HOPKIHS BAYUBU MED. CTR./4940 EASTERN AVE, BALTIMORE, MO 21224 31. Date filed (Month, Day, Year) Registrar's Signature State

ÖRIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 25291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2008 Doris Elizabeth Roberts 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5AUS6414 HIOMION TENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 27,1926 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 🖫 F Months Min. 577-30-0101 82 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Howard Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20723 U.S.A. 9595 Kings Grant Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Medical Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Frank Trimmer Ruby Lynn Woodbury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11029 Doxberry Circle Woodstock, MD 21163 James R. Roberts (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Desurial 2 Cremation 3 Removal from State Gate of Heaven Cem. 8-2-2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Witzke Funeral Homes. Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the discos, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin V SCVD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (iterate of right) that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 1 Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending

Physician /Medical **Examiner**

the attending physician

has

After this certificate

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Physician

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be natified anonce.

Baltimore,

/Medical

Directo

Funeral

2

Completed

Be

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Examiner burial-transi Physician/Medical the 2 Completed Be Certification: To filled in by the

Medical

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?
1 Yes No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

investigation

determined

6 ☐ Could not be

29c. License number 63199

DL.

SAUSBURY

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 30

dr s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and OGESH 614 EASTERN VOHRA

31. Date filed (Month, Day, Year) State Ó 6 AUG Registrar

3 ☐ Suicide

4 Homicide

32. Registrar's Signature

	For State	,	-	tificate of L		1ental Hyg		0.0	25202
	Registrar	st)	Cer	uncate of L	Jealli			08	3. Time of Death
n al	Luella M.	Stefan				Month	Day	08	7:20am
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	235-30-5457			Months Days	Hours Min.	Month Day April	28,192	9. Birthpi Count	ace (State or Foreign ry) WV
- 1-		10c. City	, Town or Lo	cation				10	d. Inside City Limits
ģ	MD Balt	imore	Whit	e MArsh					1 ☐ Yes ≱ No
ire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
<u>a</u>	10516 Vincen	t Road		1			USA		
nue		Armed Forces?	S. 13. \	Vas Decedent of Hi f Yes, sp <i>ec</i> ify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla		
2	1 Never Married 2 Married 3 • Widowed 4 Divorced	If Yes 2 XNo If Yes, Give Year or Dates:		I∐Yes 2⊠No	Specify:		Specif	y: W	hite
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					12.				
	1 ☑ Burial 🎢 Cremation 3 🗆	Removal from State	emetery, crer	natory or other plac	e) ;				
r			22	. Name and Addres	s of Facility 30	0 MAce	Ave.	Balt	O.MD
_	· (JUV)	a rous		Connell	y Funer	al Hom	e of E		
		plications that caused the deati one cause on each line.	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	disease or condition	a. OHR	BN	Conc	er			10 W	165 3 mind
		Due to (of as a consequ	uence of):					O D	.C. > , SINON
Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence)	uence of):						
mir	Cause. Enter Underlying Cause (Disease or injury that initiated events	C							
Ë	resulting in death) Last	Due to (or as a consequent	uence of):						
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hysi	9 Unknown	9□ Unknown							
	Part ii. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to		tribute to th	e cause of death?
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	by Physician/Medical Examiner To Be Completed by Funeral Director	Luella M. 4a. Facility Name (If not institution, given 10516 Vincen 10516 Vincen 235-30-5457 Usual Residence of Decedent 10a. State 10b. County MD Balt 10e. Street and Number 10.516 Vincen 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Greeify only highest grate 10. Informant's Name/Relationship (Incention 1 Repurial 10. Cremation 1	Aa. Facility Name (If not institution, give street and number)	Luella M. Stefan 4a. Facility Name (If not institution, give street and number) 10516 Vincent Road 5. Social Security Number 6. Sex 235-30-5457 1	Luella M. Stefan 4a. Facility Name (If not institution, give street and number) 10516 Vincent Road 5. Social Security Number 235-30-5457 1 M 20 F 82 Yrs. Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10c. City, Town or Location MD Baltimore 10c. City, Town or Location MD Baltimore White MArsh 10e. Street and Number 10f. Zip Code 11 Marital Status 1 Never Married 2 Married 2 Married 3 Nordowed 4 Divorced 1 Never Place 1 Never Married 2 New Married 2 New Married 2 New Married 2 New Married 3 Nordowed 4 Divorced 1 New Fare or Dates: 1 Never Married 1 Never Married 1 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 3 Nordowed 4 Divorced 1 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 2 New Married 3 Nordowed 4 Divorced 1 New Married 2 New Mar	Luella M. Stefan 4a. Facility Name (If not institution, give street and number) 10516 Vincent Road 5. Social Security Number 235-30-5457 1 M 22 F 7. Age (In yes. list birthday) Usual Residence of Decedent 106. State 106. County MD Baltimore 106. City, Town or Location White Marsh 107. Age (In yes. list birthday) Usual Residence of Decedent 108. State 109. County MD Baltimore 109. City, Town or Location White Marsh 109. City, Town or Location White Marsh 101. Zip Code 211. 62 11. Marital Statius 1	Luella M. Stefan August A	Luella M. Stefan Aa. Facilty Name (Into institution, give street and number) Ab. City, Town, or Location of Dash Ac. County	Luella M. Stefan 4a. Facility Name (If not institution, give sites and number) 10516 Vincent Road 5. Social Security Number 235-30-5457 IDM 22F 7. Age (In yrs. last birithapy) 10 more in the passion of Deader in

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Snell Aua 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland eneral 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**√** M 2□ F Director 214-40-7617 42 65 b9 MD Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at Baltimore Director NA 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or U.S.A. 21201 1100 Bolton Street Apt Apt #714 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs 2th grade Carpenter injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Turner Wilbur Nathaniel Snell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Greenapple Court, Baltimore, Md 21207 Wilbert Snell-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Qonation 5 ☐ Other (Specify) Cedar Hill 8/7/08 Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): Examiner Stage renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of) Examiner that the death certificate be executed ı physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical as attending for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas autopsy this certificate ! performed' 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a, Certifie 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who d cause of death (Item 23a) (Type, Print) m.D 31. Date filed (Month, Day, Year)-32. Registrar's Signature State AUG 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Year Physician 12.10 PM KURT tusust 3 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Bultomore BALTIMORE Rehab Extended care cart If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**M** 2□F Days Hours Min. 60-936 07/18/1954 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Baltimore City 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 641 47th St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1970 -1973 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eng<u>ineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Virginia Fugate Lewellyn Adrain Schwartz 19a. Informant's Name/Relationship (Type. Print) Bryther Llewellyn R. Schwartz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 47th St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, MD Chesapeake Crem. 2008 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Dr. Towson, MD21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastake KENAL COLL Concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day) 28b. Time of 28d. Describe how injury occurred Year) 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Show delya

and manner stated.



29c. License number

012735

Ba Gamore

August 3, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 SPARKS **Physician** MARGARET 1:00 PM AUGULT 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2000F 219-01-9217 Director 87 05-17-1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes ¥XNo Director MDBaltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2905 Freeway 21227 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental int: If item 27 is marked or Charles Schuel Gertrude Lassner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Sparks - son 2211 Hammonds Ferry Road, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I important: If ite any injury or ot August XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk Elkridge, Maryland 8, 2008 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licensee M00053 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC ORITRUCTIVE AIRWAY DUEALE . EXACERBATION UNKNOWN **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Onknown funeral director, page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ¶o 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident after death 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 Cheta LRICE AUGUST 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HANDVER STREET RALTIMORE MARYLAND

Registrar DHMH 17 Rev 1/2001

State

OXIJE IHEAGWARA,

31. Date filed (Month, Day, Year) AUG 0 6 2008

3001

32. Registrar's Signature

			For State Registrar	State	of Mar		partmen <i>ertificat</i>		Health and N <i>Death</i>	/lental H	lygier Reg. 1	ne No. 20	80	2529
			Decedent's Name (First, Middle, L.)	_ast)						2. Date of				3. Time of Deatl
	Physicia	-	Penrode Schaeff	er						July	9, 2	.008	Year	6:30 PM
8	/Medic Examin	- 8	4a. Facility Name (If not institution, g		number)		4b. City,	Town, o	or Location of Death	-		4c. County	of Death	
1	LAGIIIII	Ç'	Future Care Hom	ewood			Ba1	Ltim	ore					
	Funeral		Social Security Number 6.	.Sex 11XIM 2□ F		In yrs. last birthd	Months	r 1 Year Days		8. Date of (Month,	Birth Day, Ye	ar)	9. Birthp	place (State or Fore
	Director		213-30-8549	A W Z		75 Yrs				Apr 3	30,	1933	Mary	land
	and and		Usual Residence of Decedent 10a. State 10b. County	-	1	0c. City, Town or	Location						1	10d. Inside City Lin
	Maryl f sho	to	MD			Balti	more							¹X Yes 2□
	r 28a	Funeral Director	10e. Street and Number				10f. Zip	Code			10g.	Citizen of V	/hat Cou	ntry?
	3a o	0	3800 W. Belveder	e Avenu	ie.			2	1215			US	SA	
	death ms 2	ner	11. Marital Status	12. Was De		er in U.S.	3. Was Dece		Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or	No-	14. Race		can Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural" or items 23a or 28a-f show if item 27 is marked other than "natural" or items 2 is more than the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced		s 2 No Give		1 ☐ Yes			o i nodini otorij		Specify		ack
ည	72 ho natur Ilcat	eted	15. Decedent's (Specify only highest)	Education	d)	16a. De	cedent's Usu	ial Occu ork done	pation during most of wor ed)	king	16b	. Kind of Bu	siness/In	dustry
7	ithin ne. nan "	Completed by	Elementary/Secondary (0-12)	College	(1-4or 5+)	The state of the s			ed)					_
N	led w tygie her ti	ပိ	17. Father's Name (First, Middle, La				coc	ok	18. Mother's Nan	ne (First. Mia	dle. Mai	_food_ den Surnam		stry
Maryland	d 2 should be filed within th and Mental Hygiene. 7 Is marked other than " traumatic event, the Med	Be	Russell Richard		fer					elle J			-/	
Ĕ	hould d Me mark matic	2	19a. Informant's Name/Relationship			19b. M	ailing Address	s (Stree	t and Number or Ru				State, Zi	o Code)
	id 2 s Ith an 27 Is trau		Muriel Johnson/						vania Ave					
Baltimore,	Pages 1 and 2 nent of Health a int: If Item 27 I.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🐼 Other (Spe		m State S taté		sposition (Na crematory or	me of other pla	ace)	Date	200	. Location -	City or T	own, State
Balti	permit. Pages Department of Important: If It any injury or o		21. Signature Funeral Signature Sign	Wade,	live	eter	Balti	more		201			nore	
В			23a. Part . Enter the disease, or or shock, or heart failure. List or	Smplications than one cause or	at caused the n each line	ne death. Do not	enter the mo	de of day	ing, such as cardiad	or respirato	ry arrest,			Approximate Interval Between Onset and Death
	Physician	o A	Immediate Cause (Final disease or condition resulting in death)	a(Meta	Static	Lung	C	ances					
	/Medical xaminer		resulting in death)	Due	to (or as a	consequence of)	J							
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	rted nsit	nin	Cause (Disease or injury			-								
	execu aland	Exar	that initiated events resulting in death) Last	cDue	to (or as a	consequence of)								
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68		edi							-			-		
.O. Box	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pre	e birth 2	f pregnancy Fetal death me of death	3 ☐Ectopic p 5 ☐ Other (s		су		-		te of deliventh	very Day Year
<u>α</u>	res that the signed by the be detache	δ	Part II. Other significant condition	s contributing to	o death but	not resulting in the	e underlying	cause g	iven in Part I.			co use con		the cause of death
Ö	requires been sign hould be	eted												
l Records,	has has	Completed									Vas an autopsy performe es 2 🗓	d3/	were au prior to c death? 1 ∐Yes	topsy findings avail ompletion of cause 2 \(\square\) No
/ita	yslcian: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					1.	26. Place of De	ath Check o	nl one			
ž.	ys dir is	2	1 ☐ Yes 2 ☑ No		☐ Inpatien			CA	ther: 4 Nursing I	T				cify)
Division or Vital	ding J. After funer	ation:	27. Manuar of Death 1 V Natural 5 Pending 2 Accident investiga	(N	ate of Injury Month, Day		ne of iry M	28c. Inj W 1 [ury at ork? □ Yes 2 □ No	28d. Desci	ibe how	injury occur	red	
Divis	lospital or Attene I hours after death uneral Director; ely filled in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ZOE, FR	ace of injur uilding, etc.	y - At home, farm (Specify)	, street, facto	ery, office	e	28f. Locati City o.	on (Stree r Town, S	et and Numi State)	ber or Ru	ral Route Number,
	Hospit 4 hour Funera ely fille	ical (time, date and plac opinion, death occ					

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DAR SMAN D17537

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OAPSHOW S-SALV/A fullware Core

31. Date filed (Month, Day, Year)

32. Tegistrar's Signature

State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Baby Girl Stokes Twin B /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 KF 2008 45 July 29, Maryland infant Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County ms 23a or 28a-f show must be notified at 1√2 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21221 USA 616 Hopkins Landing Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must voice. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dontee D. Stokes Shawna T. Miller ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Wolfe Street Baltimore, MD 21287 Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Ronald Director Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Extreme prematurity
Due to (or as a consequence of): **Physician** disease or condition resulting in death) Extreme /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home Hospital: 1 Yes 2 No 1 5 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🛣 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES -000 29,2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 EDWARDSON MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 0 6

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item 20b per fhe882 8-6-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4a. Facility Name (If not institution, give street and number) 131 2008 11:420 August /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Ray dell to de de de la verte Northwet Masortell Center Poul ho If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛱 F Director 222-07-3946 10/25/1920 DE Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 □Yes 2 No CARROLL. MD MARRIOTTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 1921 BABBS COURT Completed by Funeral 21104 U<u>SA</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 and Mental Hygiene. 1 ☐ Yes 2 No Specify: WHITE Specify 3 V Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental BRONFIN **JACOB** FLORENCE LEVY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
D-partment of Health ar
Inportant; If item 27 is
any Injury or other trau JUDITH SCHMIDT / DAUGHTER 1921 BABBS COURT, MARRIOTTSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State **05** 08/2008 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 08 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee SCL LEVINSON & BROS., 8900 REISTFRSTOWN ROAD, PIKESVILLE,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 NO 1 □Yes within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J 6056 4 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 5401 010 32. Registrar's Signature ami State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Coaste

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 5:50P RAYMOND SHARP 2008 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIEN NURSING HOME - MAYS CHAPEL TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/28/1917 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1XM 2□F 213-03-0038 91 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at 1 ☐ Yes 2 No MD BALTIMORE Director BALTIMORE 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number o e ns 23a e #503 USA 14. Race - American Indian, Black, White, etc. 2 POMONA EAST. 21208 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 ral", or Items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces: 1∑Yes 2 □ No ARMY If Yes, Give Year or Dates:AIR CORP 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER GRANITE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic even **JACOB** SHARP **CLARA** SLOVIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #503, BALTIMORE, MD ROSE SHARP / WIFE POMONA FAST, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/05/2008 BALTIMORE HEBREW REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 e of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, jet only one cause on each line. 23a. Par 1 Enter the disease show, or heart failure. Immedi e Cause (Final disease or condition resulting in death) PNEUMONIA WHR SEPSIS **Physician** days /Medical Due to (or as a consequence of) **Examiner** COMPRESSION SPINAL CORD Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine OSTEOPOROSIS FRACTURE The law requires that the death certificate be executed 12 burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate ha To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Type, Print) 30. Name and address of person who complet . Charles Street Sucte 200/ Balto M) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Tygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

For State Registrar

Funeral Director

Division of Vital Records, P.O. Box 68760, Total vitte

in 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and plately filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Cartification: To Be Completed by Dhysician Modical Evaminer
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Physicia Medic		CArolyn Thomas	Month Da		10:49 M
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RANA STOWN	40	. County of Death	MUTE
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year)	9. Birth	place (State or Foreign ntry)
irector		Usual Residence of Decedent	7AY 16, 1941	1 South	Carolina
a-f show	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
or 28	Director	10e. Street and Number 10f. Zip Code	10g. Ci	tizen of What Cou	ntry?
ns 23a	Funeral	913D SUNSET RIAGE ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	fy Yes or No-	14. Race - Amer	
Department of from any working from 1 years. In particular, or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ange.	þ	Armed Forces? 1 Never Married 2 Married I Never Married 2 Married I Never Mar	can, etc.)	Black, White,	etc.
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ed oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (I	1. 4		
s mark umatik	7	19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural I	Route Number, City	-	p Code)
em 27 i		20a. Method of Disposition 20b. Place of Disposition Date 20b. Place of Disposition (Name of Date Date Date Date Date Date Date Date	47d 1/15 tow	ocation - City or T	1133 Own State
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any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Signature of Funeral Service Licensee	3431	tegrot in	DAL AVE
		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line	respiratory arrest,	(10) 10 5	Approximate Interval Between
sician ledical		Immediate Cause (Final disease or condition resulting in death) a. MYDCANDLUL Infanction Due to (or as a consequence of): CORONARY ARLLY DISC. Due to (or as a consequence of):			Onset and Death
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igned b	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
peen s	eted	Diabetes meilitus	1 Yes 2		
icate has r, page 2 s	Completed		24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of 2 □No
s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	Check only one)	6 □Other (Spec	ifu)
To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detach	ation: To		d. Describe how inju		
al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	f. Location (Street a City or Town, Stat	nd Number or Ru e)	ral Route Number,
ne Funera	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and place, and place and pla	nd due to the cause(d at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
To tl	M	29b. Signature and title of certifier 29c. License number 39 834	29d. Da	ate signed (Month	, Day, Year)
Y		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIANA FENG MD 4 LLO WILKERS USE BA	ur, mo		
Sta Registr		DIANA FENY MD 4660 WCCKERS We Ba			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year **Physician** John William Thompkinson Aug. 6:10 PM /Medical 4a. Facility Name (If not institution, give street and number) Crownsville of Death 4c. County of Death Examiner A.A. County Fairfeild Nursing Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/18/1952 9. Birthplace (State or Foreign 6. Sex Funeral Days Hours Country D • C 1 M 2 □ F 56 214-62-6056 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Baltimore City A.A. County MD 1 XYes 2 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Old Riverside Rd. 21225 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 See 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 □Yes 2 🛣 o If Yes, Give Year or Dates: Vietnam Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Alliance Elementary/Secondary (0-12) College (1-4or 5+) Roofing Roofer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thompkinson Joan Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Thompkinson/Wife 200 Old Riverside Rd. Balt. MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 2008 Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Dr. Towson. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due ti (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s certificate 1 □ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 ☐ Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 4+ Name and address of completed cause of death (Item 23a) (Type, Print)

Registrar
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State

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Registrar's Signature

Highway Sw alin Burne MO 21061

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** TAYLOR 03.50 PM ROY 5 08 JULY 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges County Greater Lawrel Healin And Rehab Louvel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Min. Months 1 ☑ M 2 ☐ F Director 277-32-2059 1935 Ohio July 1. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventine must be notified at 10a State 1 □Yes 2 ¬No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1838 Cedar Drive 21144 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 56-59 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ð 3 ☑ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Senior Computer Scientist Dep. of Defense NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ပ္ Elza Taylor Hilda **Bates** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a : If item 27 or other t Lorn A. Taylor- son 8013 Ponderosa Drive, Severn, Maryland 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any injury or ott 20a. Method of Disposition 1 Properties 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mamorial Park | Aug.4,2008 | Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd. Elkridge, Maryland 21075 M01234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate **Physician** metastatic Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the r use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy p in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign artery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Coronory Hyperterion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s has autopsy certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Hospital or Attending 1 Natural n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 053411 MI 200 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherader Galland Fox 1 弁 210 20715 Bowle 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2008 for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Η. Tabeling Joseph \mathbf{a}^{M} August 05 2008 5:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Dove House Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M M 2 □ F 214-20-9775 80 Sept 2, Maryland **Director** Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits show iral", or items 23a or 28a-f shov Examiner must be notified at Baltimore Reisterstown 1 □Yes 2 No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with theath and Mental Hygiene.

PR 27 is marked other than "natural", or items 23a or ? USA 21136 302 Cantata Court Apt 401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 Mo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 X Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 is marked o Joseph H. Tabeling Katherine Randall ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other trau 4016 Gill Ave. Hampstead, Md. 21074 Mr. Joseph R. Tabeling/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 8-8-08 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Salice Licenses <u>1050 York Rd. Towson, Md.</u> 23a. Part 1. Enter the disease, br complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) letastate **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed CAD Due to (or as a consequence of): physician a P.O. Box 68760, DDV Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the 1 ☐ Yes 2 ☐ No 9 I Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform certificate 1 □Yes 2 No 2 🗔 or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | □ Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 101/E 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0054218 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcoly dun. 10+ Kaneva 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

08-05818 Troy Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician	1/	Registrar 1. Decedent's Name (First, Middle,Li				son Jr.		2. Date of Deat	h	3. Time of Death
ledical Éxamine ে		4a. Facility Name (if not institution, g	ive street and number)		lilson		Location of Death	Month July 29, 20	4c. County of De	1825 hrs
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any		10a. State 10b. County		10c. City,	Town or Loca	tion				10d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once	Ulrector	10e. Street and Number				10f. Zip Code	21213	10	0g. Citizen of What C USA	
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. If an 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		3036 Clifton 11. Marital Status	12. Was Decedent			as Decedent of Hi	spanic Origin? (S		- 14. Race - Am	nerican Indian, Black,
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Baltimore, permit. Pages I ar permit. Pages I ar Department of Her Important: If ite injury or other tr		1 XBurial 2 Cremation		ite c	rematory or o	ther place)				·
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Box 687 c death certific the attending p ed for use as th	sician/	past 12 months?	1 Live birth 4 Pregnant at	time of dea		etal death 3 other (Specify)	Ectopic pregn	ancy	Month	Day Year
O. Bo trthe dear by the a ached fo	≥[1 Yes 2 No 9 Unkno	9 OIIKIOWII	but not re	eulting in the	underlying cause	given in Part I	23e Did to	phacco use contribute	e to the cause of death?
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Vital Recysician: The list certificate director, page	Be C	25. Was case referred to medical examiner?	Hospital:				ce of Death (Check	only one)		
Division of Vital Records, tall or Attending Physician: The law requint as after death al Director: After this certificate has been so a Director and the function to the fine of the function	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time of		Other Nursi		Residence 6 O	ther:
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ivisi or Att after de Direct	Certification:	2 Accident Investig 3 Suicide 6 Could n	ot be 28e. Place of In	jury - At ho	me, farm, str	eet, factory, office	building, etc.			Rural Route Number, City
Dospital hours and filled		4 Homicide determi	(Opcomy) LOC						State) Aisquith Street, Ba	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only Certifying Phys	ician: To the best of my							
F is F 8	ğ	29b. Signature and title of certifier	and manner stated.			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
T		Mundle aler	My M	>		0.0	.M.E.		July 30, 2008	
4		 Mame and address of person when Russell Alexander MD. 	Assistant Medic	,	,	1 Penn Stree	t, Baltimore, N	1D 21201		
Sta	-	31. Date filed (Month, Day, Year)	2. Registra		re 🌶					
Registr	ar	AUG 0 6 201	18 Alastoria	15.	Goan	23			00145	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** handt 8: Z4AM ROY WARREN CLAUDE 12008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne BALTIMORE WASHINGTON MEDICAL CENTER (7) Rm Knr 717 Hours Min. 8. Date of Birth (Month, Day, Year) 9/4/1919 If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 M 2 □ F 88 IOWA 198-01-2472 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No ANNE ARUNDEL GLEN BURNIE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 509 Kintop Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. þ 3 Widowed 4 Divorced ear or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M General Motors Assembly 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f and 2 should be fi Health and Mental H Dorothy May Burnham Warren Claude ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
509 Kintop Rd., Glen Burnie MD 21061 19a. Informant's Name/Relationship (Type. Print) Mrs Violet Warren/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 8/4/2008 Catonsville, MD Metro Crematory 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA 21 Crain Hwy SE Glen Burnie MD 21061 Signature of Funeral Service/Licensee 21 M01364 421 Crain Hwy SE 23a. Part1. Enter the died se, or or my lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 68 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Box 68760 at ending physician Physician/Medical been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy performed certificate 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No **N**_Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name and address of persor

31. Date filed (Month, Day, Year)

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ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** 17.20 PM William F. Weber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Agnes N/A Itimore 9. Birthplace (State or Foreign Country) Maryland Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex f Under 1 7. Age (In yrs. last birthday **Funeral** Days Hours 1**™** M 2□ F 89 Director 10/19/1918 215 03 8543 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 🗑 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21227 2808 Alabama Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify à Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien. Importent: If flem 27 is merked other the eny Injury or other traumetic according to the page once. Truck Driver Trucking 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph F. Weber Viola Rixie ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6602 Rapid Water Way Unit 301 Glen Burnie, MD 21060 Mary Chapman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 08/05/2008 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature eral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway Approximate Interval Between Onset and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 687605 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 2 Accident Injury within 24 hours after death.

To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature 0 6 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20a-c, 22, perFH, 6822, 8/12/08, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** IISA SOON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-72-9575 41 Oct 17, 1966 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1616 Lamley Street 21205 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Willie Weathers Georgia Ellis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Dawson/sister 723 N. Belnord Avenue Baltimore, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2X Cremation 3 Removal from State 8-2-08 Baltimore, MD Greenmount Cem. 4 □ Donation 5 Other (Specify) in state 22. Name and Address of Facility Chatman—Harris Funeral Home 5240 Reisterstöon Rd. Baltimore, MD. 21205
Baltimore, MD. 21205 21. Signature of Funeral Service Ronald 21a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final **Physician** (as a consequence of): 6 DAV disease or condition resulting in death) /Medical Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 □ No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **X**No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No. 2 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 npatient Other: 4 \sum Nursing Home 1 Tes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation

or Attending Physician: The law requires that the death certificate be executed Box 68760, completely filled in by the funeral director, page 2 should be detached for use as P.O. Division of Vital Records,

s after death. I Director: After the To the Hospital
within 24 hours a

> State Registrar

Medical

METER 31. Date filed (Month, Day, Year) 2008

LEAR

29b. Signature and title of certifier

Could not be determined

3 Suicide

4 - Homicide

(check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-DOG

29c. License number -

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MEDICAL

HOSPITAL, 600 North Wolfe St, Baltimore, MD, 21287 JOHNS HOPKINS

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05744 State of Maryland / Department of Health and Mental Hygiene 2008 25309 Jahkeem Akram 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 27, 2008 0603 hrs Jah 'Keem Bilal Akram Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salisbury 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 2 Hours Min Days Director 05/26/2008 1 X M 2 Maryland n/a Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. County 1 X Yes 2 No Wicomico Salisbury 28a-f show Maryland death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 1015 Fairground Dr., apt. 4 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No. African/ Yes 2 X No specify: Specify hours after Widowed 4 Divorced Yes Give Year American þ 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than n/a n/a n/a 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bilal M. Akram Oleisha T. Conaway Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is m r traumatic 1015 Fairground Dr., Apt. 4, Salisbury, MD 21801 Oleisha T. Conaway/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Springhill Memory 8/1/08 Hebron, MD Other Specify: Donation 5 ardens 22 NHOITOWAY FUNEral Home Professional Salisbury, MD 2 nature of Funeral S, rvice Licensee Association 501 Snow Hill Rd., Salisbury, MD 21804 Wommow art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Sudden unexplained death in infancy Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,28a-f, perME, g883 9/16/08 TT X UNPENDED signed by the attending physician be detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be a thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia mpletely filled in by the funeral director, page 2 should be detached for use as the buriar Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live hirth Fetal death nast 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed' ✓ Yes ✓ Yes 2 2 No 26.Place of Death (Check only one) 25. Was case referred to medical æ examiner? DOA Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 1 V Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: Natural Yes 2 X No 5 Pending Fnd 7/27/08 Fnd 5:21 ann 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1015 Fairground Dr. Apt. 4 Salisbury, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be found at home Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the] and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 28, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

			1 - For amend #5 Per State Registrar	State of Ma	ryland (De C	partment of F <i>ertificate of</i>	lealth and N <i>Death</i>	lental Hy! ا	giene Reg. No. 2 (800	25310
h,	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	ath Day	Year	3. Time of Death
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). 	Examin	er	4a. Facility Name (If not institution, given NATIONAL NAVAL		ENTER		or Location of Death			NTGOM	IERY
- suppre	Funeral Director		5. Social Security Number 268-28-6588 1		e (In yrs. last birthda 78 Yrs	ay) If Under 1 Year Months Days		8. Date of Birl (Month, Da 08/15/1	th v. Year)		lace (State or Foreign
200	ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
Man	a-f sh	cto	VA Loudo	un	Sterlin	ıg					1 ☐ Yes 2X No
4	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
4	s 23a nust l		210 Lake Drive	12. Was Decedent I		2016		if . V AI-	USA	ce - Americ	on Indian
d 21215-0036	and Mont be bred within 12 hours after death with the wallyfal and Monthal Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 25 N If Yes, Give Year or Dates:	4o	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rican, etc.)	Bla Specifi	ck, White,	
5-0-2	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of work	king	16b. Kind of E	lusiness/In	dustry
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_ (n = 0 &	BeC	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle,	, Maiden Surna	me)	
yaı yaı	and Mental I is marked or raumatic eve	흔	Lilburn Floyd				Ruth Bar				
, Maryland	ealth and m 27 is m	n si	19a. Informant's Name/Relationship (Earl J. Archer,	**	nd 210	ailing Address (Street Lake Dr.	, Sterli	ng, VA	20164		
Baltimore,	permit. Tages I and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)	cemetery, o	sposition (Name of crematory or other place of National	08/0	8/2008	20c. Location Triang	•	
Bal	Depar Impor any Ir		21. Signature of Funeral Service Licer	1500		22. Name and Addre	•	1 11	721 E		
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vision or Vital Records, P.O. Box (the attending plant of the attending plant of the ast	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	су			ate of delivionth	ery Day Year
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	certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea				
ō	er this	1: To	1 ☐ Yes 2 🕅 No 27. Manner of Death	28a. Date of Inju		e of 28c. Inju	4 U Nursing H	ome 5 ☐ Resi 28d. Describe	now injury occu		fy)
io i	ath. or: After	ation	1 XNatural 5 ☐ Pending investigation		y Year) Inju		ork?]Yes 2∐No				
Division or	5 2 2 2 5	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injubulding, etc		street, factory, office		28f. Location (City or To	Street and Nun wn, State)	ber or Run	al Route Number,
1	within 24 hours after deat To the Funeral Director completely filled in by the	Medical ((Check only 2 Medical Examone)	nysician: To the best miner: On the basis o and manner sta	f examination and/o	or investigation, in my	opinion, death occu	e, and due to the urred at the time	, date and place	e, and due	to the cause(s)
ļ	To	2	29b. Signature and title of certifier	hilp	MD	0101	se number 1243094 (1		29d. Date sign	1/0	8
			30. Name and address of person who ANDREW I. PHILI		eath (Item 23a) (Ty USN	pe, Print)		AL NAVAI DA MD 20			NTER
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1.00	וכמווזמת	DR FID Z	2007 200	,,,	
21:2:	Regist		AUG - 6 20	08 Been	, A A						

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Į.			Registrar 1. Decedent's Name (First, Middle,	Last)			inicate of	Dean	_	2. Date of [Death			3. Time of D	
R	Physicia /Medic	_	MARY ELIZA	BETH ALDR	ICH					JULY Month	21,		Year 008	1:30	A M
	Examin		4a. Facility Name (If not institution,				4b. City, Town,		of Death			c. County	of Death		
2		**	CALVERT MANOR HE 5. Social Security Number 6		Age (In yrs. last b	oirthday)	RISING If Under 1 Year		er 24 Hrs.	8. Date of E		CECIL	9 Birtho	lace (State or I	Foreign
и	Funeral Director		079-03-4773	1□M 2 X F	92	Yrs.	Months Day	s Hours	Min.	DEC.	Day, Year	15	NEW :	try)	or engin
*	pu. »		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City	Limits
	daryla f shov ed at	o	MARYLAND CECIL		RISING									1 ☐ Yes 2	_
	r 28a- notifi	Director	10e. Street and Number		RIOIM	3 50.	10f. Zip Code				10g. C	itizen of W	/hat Coun	try?	
	th with	al D	1881 TELEGRAPH R	D.			21911				USA	1			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 2 N			ecify Yes or I Rican, etc.)	No-	Black	e - Americ k, White, WHI	etc.	
21215-0036	72 hou natura lical E	Completed	15. Decedent's		16	ia. Deced	dent's Usual Occ kind of work don	upation e during mo	ost of work	ina	16b. I	Kind of Bu	siness/Ind	dustry	
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о О	filed v Hygic other 1		17. Father's Name (First, Middle, La				KI MODIC		her's Name	e (First, Mida					
lan	Jid be Jental rked c	To Be	GEORGE WILLIS EL	LIOTT				PEA	RL HE	LFER					
Maryland	2 should I		19a. Informant's Name/Relationship		I .		ng Address (Stre					,	State, Zip	Code)	
	1 and 2 Health tem 27 i		BARBARA A. FINCH 20a. Method of Disposition	/DAUGHTER			PENCADER psition (Name of				_	ocation -	City or To	wn State	
Baltimore,	Pa ant:		1 ☐ Burial 2 【 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	ate ceme	tery, crei DALE	matory or other p	ORY	JULY 200	8	NEW	ARK,	DE		
Ba	permit. Departimonts any inj		21. Signature of Funeral Service Li	aug)		1.0	2. Name <i>a</i> nd Add 00 N. DU								
	3,53		23a. Part1. Enter the disease, or shock, or heart failure. List of		ised the death. Do							,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition		IMER DEME									Onset and De	ath
1	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequenc	e of):							-		
	ecuted ind transit	Examiner	Cause (Disease of injury that initiated events resulting in death) Last	c											
8760,	cate be executed physician and the burial-transit	dical E	rooding in doubly East	d Due to (or	as a consequenc	e or):									
9	tificate g phy as the	ledic		0.							- 6				
.O. Box	uires that the death certific signed by the attending p Id be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live bir	ome pf pregnancy th 2 □ Fetal dea nt at time of death n		⊒Ectopic pregna ⊒ Other <i>(specify)</i>				- 2	23d. Dat Mor	e of delive	ery Day Ye	∍ar
S, P	ss that gned b	by Pł	Part II. Other significant condition	s contributing to dea	th but not resulting	in the u	nderlying cause	given in Par	t I.	23e. Di	d tobacco	use contr	ribute to th	ne cause of dea	ath?
ord	w require been siç should b	ted								1[] Yes	2□ No	3 ☐ Prob	ably 4 XX Un	ıknown
or Vital Record	r: The law requires that the licate has been signed by th	Completed								1□ Yes	itopsy erformed? s 2 X N	, c	Were auto prior to co death? □ Yes	psy findings av mpletion of cau 2□ No	/ailable use of
<u>=</u>	/sicial	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 In	oatient 2 ☐ ER/0	Outpatier	nt 3 DOA	N		h <i>(Ch</i> eckonl ome 5⊟Re		6.□Oth	er <i>(Snecit</i>	(v)	
n Or	ng Phy fter thi		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of		. Time o				28d. Describ				,,	
Sion	Attending Physician: r death. ector: After this certification by the funeral director,	catic	2 Accident investiga 3 Suicide 6 Could no	tion			M 1	☐Yes 2[0011 11	(0)	v			
Division	e Hospital or Atteno 24 hours after deatt Funeral Director: etely filled in by the	Certification:	4 ☐ Homicide determin	ed 20e. Flace o	f injury - At home, g, etc. (Specify)					City or	Town, Sta	ite)		al Route Numb	er,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ledical	(Check only 2 Medical E	Physician: To the basaminer: On the basaminer and manner	is of examination		nvestigation, in m	y opinion, d	leath occur		ne, date a	nd place,	and due t	o the cause(s)	
	with Con	M	29b. Signatule and title of centiler)		N	ND D	005	564	49		Y 23		Day, Year) 18	
	5		30. Name and address of person w	onsor	111 We	5+	High	54.5	int.	e 30	2 E	Kto	np	10219	12/
2	Sta Registi		31. Date filed (Month, Pay, Year)	4 2008	Strar's Signature	* /	porte								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Langston D. Augustus A M July 21 2008 9:01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You Apr. 14, If Under 1 Year If Under 24 Hrs. Social Security Numbe 9. Birthplace (State or Foreign **Funeral** 229-26-7543 ₩ 2 F Months Days Hours 1929 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5605 S. Marwood Blvd. #401 20772 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

MXYes 2 1 No 5 1 - Year or Dates 1 95 3 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Black Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Federal Protective Serv. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Augustus Saretta Cope 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 S. Marwood Blvd., #401, Upper Marlboro, MD 20772Rosa Augustus - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 7/30/2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bell & Johnson Funeral Home, PA 21. Sign of re of Funeral Service Lice p503 Old Branch Ave., Temple Hills, MD 20748 Part1. Enter the disease, or brock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician Costionsofath /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ass IF FEMALE: led by the attendin detached for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Filmorlation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? /es 212 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of D ath 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred Injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar M-N

31. Date filed (Month, Day, Year)

30_Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0064801

Suite 307

Clinton, mo

		_	For State Registrar		aryland		artment of tificate of	Health and Death		Reg. No		25313
Ph	ysicia		Decedent's Name (First, Middle, Land)	•					2. Date of D	eath 18	y 2008	3. Time of Death
	Medic	al -		erson								9:30 А м
Ex	amin	er	4a: Facility Name (If not institution, gi	ve street and number)			4b. City, Town,	or Location of Dea	th	40	. County of Deat	h
	eral ector	3		Sex 7. Ag	ge (In yrs. las	t birthday) Yrs.	Takoma If Under 1 Yea Months Day	r If Under 24 Hrs		irth	Montgome 9. Birt 926 Nor	ery hplace (State or Foreign untry) th Carolina
pu »		-	Usual Residence of Decedent 10a, State 10b, County		10c. City, T	Town or Lo	cation					10d. Inside City Limits
laryla	20	5	DC			shing						1 ☑ Yes 2 ☐ No
the A	鲁	ect	10e. Street and Number		, mar	5111116	10f. Zip Code			10g. C	itizen of What Co	untry?
ath with	and ten	Funeral Director	6001 4th. Stree				2001	1			USA	
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene himpertent; or Items 23s or 28s-1 show	Examinera	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ②Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:)		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☐ N	Hispanic Origin? (: iban, Mexican, Puel o <i>Specity:</i>	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
5-0	lical	Completed	15. Decedent's E (Specify only highest gi			16a. Deced	dent's Usual Occ	upation e during most of wo	orkina	16b. h	Kind of Business/	Industry
2 E E	N N	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use reti	red)		II S	. Post (Office
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ary sho	E L		19a. Informant's Name/Relationship	(Type, Print)				et and Number or F				
and and a	er tra		Denise Davis/Da	ughter				. N.W. Wa				
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alti mit. partir	in in	1	21. Signature of Funeral Service Lice	nsee		22	. Name and Add	ress of Facility	Marshall	S	uneral 1	Iome
m 88 E	5 S		Oct May	shall		4:	217 9th.	St. N.W.	. Washin	gton	, D.C.	20011
Physic /Med	lical		23a. Part Pinter the disease, or cor shoot or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each l	ine.	rotic		ying, such as cardia		arrest,		Approximate Interval Between Onset and Death
Exam	iner		Sequentially list conditions,	b. Sepsi								
p	sit	luei	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ut as	a consequer	ice of).						
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587 icate	s the	dlcal		d								
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dS, P.	d be detached f	by	Part II. Other significant conditions	contributing to death t	out not resulti	ng in the u	nderlying cause (given in Part I.				the cause of death?
Records, The law requires the has been signe	should	Completed							24a, Wa	6 30	24h \\/200	utopsy findings available
Rec ne lav	CV	m							aut	opsy formed?	prior to death?	completion of cause of
D : T	r, pa		20.00	· · · · · · · · · · · · · · · · · · ·					1 □ Yes		o 1 🗆 Yes	2□ No
of Vita Physician: rthis certifica	irecto	o Be	25. Was case referred to medical examiner?	Hospital:	2055	2/0.		\the a a	eath Check only		2 CC 2 22	- 4.1
A A SHE	ra di	F 1	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpati		VOutpatier 8b. Time of	I JUDOA	4 EM Nursing	Home 5 ☐ Res 28d. Describe		6 □Other (Spe	cify)
ding P.	fune	ţ	1 Natural 5 Pending	(Month, Da	y Year)	Injury	W	ork? □Yes 2□No	200. 200020		,	
Division of Vital or Attending Physician: 1 after death. Director: After this certifical	in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place of In	jury - At homo tc. (Specify)	e, farm, str				(Street a		ural Route Number,
DIVISION TO THE HOSPITED OF ATTENION WITHIN 24 HOURS After death To the Funeral Director:	completely filled in by the funeral director, page	Medical C	Zie Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner si	of examination	udge, Jean n and/or in	hoccurred at the vestigation, in my	time, data and plan opinion, death occ	te, and due to the curred at the time	e cause(e, date ar	s) and manner and place, and due	stated. to the cause(s)
o the	отріє	Me	29b. Signature and title of certifier	and mariller s				nse number		29d. D	ate signed (Mont	h, Day, Year)
الما	8		•	4 /	MD)		06010	00		1-22	
-(30. Name and address of person who Tahmina Ahmed, M	completed cause of 831 Un	death (Item 2 iversi	^{3а) (Туре,} ty В1	Print)	Silver Sp	ring, M	D. 2	0903	
TVG y	* Sta		31. Date filed (Month, Day, Year)	EF.	rar's Signatur		A -					
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			For State	State of M	larylan		rtment <i>tificate</i>			ind Me		giene Reg. No.	200	18	25311
1		7	Registrar 1. Decedent's Name (First, Middle, Last)			001	imouto	07 2	Journ	2	. Date of Dea	ath	200	10	3. Time of Death
6	Physicia /Medic		Lula McMillan B	rooks							Month July 2:	2 Day	200	ear)8	23:05 PM
	Examin		4a. Facility Name (If not institution, give s	treet and numbe	r)		4b. City, To	own, or	Location of	f Death		4c.	County of	Death	
, ,	~		Calvert Manor Heal 5. Social Security Number 6. Sex				Risin If Under 1			DA Hre o	. Date of Birtl		ecil	Diethe	Naco (Ctata av Favalan
	Funeral Director			M XXF	83	ast birthday) Yrs.		Days	Hours	Min.	(Month, Day	v, Year)		Cour	place (State or Foreign htry) h Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	Maryl I-f sho fied a	tor	Maryland Cecil			North	East								1 ☐ Yes XX No
	th the	Director	10e. Street and Number			1101 011	10f. Zip C	Code				10g. Citiz	en of Wha	at Cour	ntry?
	s 23a		137 Kirks Mill Lan					2190					ited		
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9	2 hou natura ical E	ted	15. Decedent's Educ	cation		16a. Deced	lent's Usual	Occupa	ation	of working		16b. Kir	nd of Busin	ness/In	dustry
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a E	rmit. I spartm portal y inju		21. Signature of Funeral Services license				. Name and			y Cr	ouch F		_		,
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Records,	he law has t ge 2 s	Completed									24a. Was a autop		l prid	re auto or to co ath?	ppsy findings available mpletion of cause of
			25. Was case referred to medical						26 Place	of Death (1□ Yes Check only o	2 No	1]Yes	2/2/10
2	Physicil this cer al direct	To Be	examiner?	lospital: 1 🔲 Inpa	tient 2	ER/Outpatien	t 3 DOA	Othe	or		e 5 ☐ Resid		G □Other	(Speci	(y)
0	ing Ph (fter th Ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, E	ijury Day Year)	28b. Time of Injury		c. Injur Worl			d. Describe h	now injur	y occurred		
Division or	l or Attending Pt after death. Director: After th I in by the funeral	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Place of i	niun, - At ho	me farm etr.	M ant factory		Yes 2□N		f Longtion /6	Strant an	ul Bloombac	or D	al Route Number,
2	alor A after Il Direction by	Certification:	4 ☐ Homicide determined	28e. Place of i building,	etc. (Specif)	/)	out, ractory,	omoo		20	City or Tow	vn, State)	Or Hare	arrioute Number,
	Hospita 4 hours Funera ely fille	edical (29a. Certifier 1 Certifying Phys	sician: To the bes	of examinat	wledge, death	n occurred at vestigation, i	t the tin	ne, date and	d place, an	d due to the	cause(s) date and	and manr	er as s	stated. o the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medi	one) 29b. Signature and title of certifier	and manner		\			e number						Day, Year)
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,	/		30. Name and address of person who co	mpleted cause of	death (Nem	28a) (Type,								1'	
	0		Joseph K. Weidner	JAMA	ioi C	OICNIC	1 Wa	الم	Ste A	Risi	ng Su	-01	MD_	21	911
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture	61	O							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician Georgia Ruby Boyd July 22 2008 05:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗙 F Director 213-36-8699 89 Sept. 27, 1918 North Carolina Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21911 USA 1881 Telegraph Road Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 2 **№** No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify 3 ₩ Widowed 4 Divorced 'natural" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Wiley William Duvall Cora Elizabeth DeBoard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shi Department of Health and Important: If Item 27 is m any Injury or other traum. once. Carolyn Meekins/Daughter 123 Jethro Street, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 7-24-2008 Hopewell Cemetery Port Deposit, MD 21 Sqnatur of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. ichaso 111 S. Oueen Street, Rising Sun, MD 21911 Approximate Interval Between Onset and Death Part . Enter the disease, or complica shock, or heart failure. List only one or complication that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi physician a Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Por Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏I Inknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s certificate ha 2 No 2 D No 1 ☐Yes 1□ Yes 25. Was case referre o medical 26. Place Death (Check only one) examiner' Other: 2 No 1 ☐ Ye**ş** 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation nours after death.

neral Director: A
filled in by the for 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar WM. 127

31. Date filed (Month, Day, Year)

JUL 2 4 2008

32. Registrar's Signatu

			For State Registrar	State	of Maryl		artment of H rtificate of I		nd Me		giene leg. No2	800	25316
	Physicia		Decedent's Name (First, Middle, Lo	Last) uis Thomas	s Balaba	ın			2	2. Date of Dea Month July	th Day 20	Year 2008	3. Time of Death 6:54 a M
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of	Death	- J		unty of Death	
			221 Truck House	e Road			S	everna	Park			Anne	Arundel
	Funeral		5. Social Security Number 6	. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 2	Min. 8	B. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		206-18-1030	1⊠M 2□F		83 Yrs.	Worting Days	Tiodis	IVIII t.	August			nsylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	vestion					1	0d. Inside City Limits
	shov shov	J.		0 1		only, to this of Ed		:1 C	and no			Ι'	1 ☐ Yes 2 ☒ No
	the N 28a-f lotifie	ect	Maryland Prince 10e. Street and Number	George's			10f. Zip Code	ilver S	phring		10a Citizen	of What Coun	ntry?
	with	ä		4 Dand A	011		101. 21p 0000	20904			. og. ozo	U.S.A	
	ns 23	Funeral Director	3152 Gracefiel 11. Marital Status		cedent Everi	n U.S. 13.	Was Decedent of H	ispanic Origi	in? (Speci	ify Yes or No-	14.	Race - Americ	
	fter d r iten iner	Fun	1 ☐ Never Married 2 ☐ Married	Armed F	Forces? 2 🗌 No		If Yes, specify Cuba	an, Mexican,	Puèrto Ri	ićan, etc.)		Black, White,	etc.
	urs a al", o Exam	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	aive Dates: W	WII	1 □ Yes 2 ☒ No	Specify:			Sp	ecify:	White
ה ה	72 ho	ted	15. Decedent's (Specify only highest		n	16a. Dece	dent's Usual Occup	ation	of working	,	16b. Kind	of Business/Ind	dustry
7	thin 7 e. an "r Med	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done of DO NOT use retired	t)	or working	,			
7	ed wi ygien er th t, the	Completed			3		Operations						s Service
<u>a</u>	be file tal H d oth	Be	17. Father's Name (First, Middle, La	•				18. Mother		First, Middle,		rname)	
<u>Z</u>	ould Men narke	မ		rank Bala	ban	1				nna Bela			
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship				ng Address (Street						Code)
ָר ב	1 and Healt em 2 ther 1		Marilyn B. Durant 20a. Method of Disposition	- Daught		3186 b. Place of Dispo	Sharp Road	, Glenw	vood,			ion - City or To	wn State
2	nt of nt of :: If It		1 ☐ Burial 2 🗷 Cremation 3		n State	cemetery, cre	matory or other plac	i i	/	/2222		•	
allillo	artme artme ortant injury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice				oln Cremato 2. Name and Addre		07/23	/2008	Brenty	wood, Mar	ryland
0	Depart Impo		Musling	Wille,	1		lines-Rinald 1800 New Ha			me, Inc.	er Snr	ing Mar	vland 20904
	* 11		23a. Part1. Enter the disease, or co	omplications that	caused the d			_				ing, nar	Approximate
	Dhysisian	S in	shock, or heart failure. List or Immediate Cause (Final	nly one cause on									Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a		carcinoma	of Colon					-	1 year
	Examiner [.]				(0) 00 0 00								
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a con	sequence of):							
	cuted nd ransit	Examiner	that initiated events	с									
5	e exe ian a urial-1	E	resulting in death) Last	Due to	o (or as a con	sequence of):							
0/00,	icate be executed physician and s the burial-transit	dical		d									
0	entific ding p	/Med	IF FEMALE:	220 If you o	utoomo of or	agagagay							
ממ	attend for us	sician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 🗆 I	Fetal death 3	Ectopic pregnancy	′			23d	 Date of deliveners Month 	ery Day Year
j	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unk	gnant at time nown	ordeath 5t	Other (specify)						
ŗ.	sIcian: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Phy	Part II. Other significant condition	s contributing to	death but not	resulting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to the	ne cause of death?
ecords,	uires sign Id be	d by								1 🗆 Y	′es 2⊠1	No 3 ☐ Prob	pably 4 □Unknown
5	w req beer shou	Completed		•						24a. Was a	an 2	24b. Were auto	opsy findings available
ב	he la e has age 2	mc								autop perfoi	rmed?	prior to co death?	mpletion of cause of
[g	an: T tificat or, pe	e C	25. Was case referred to medical					26 Place	of Death /	1□ Yes (Check only o	2 X No	1 ☐ Yes	2□ No
	Physician: r this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	OF:	-			☑Other (Specif	Daughter's Residence
5	g Ph ter th	n: T	27. Manner of Death		e of Injury onth, Day Yea	28b. Time o	of 28c. Injur Wor			Bd. Describe h			,, 1002201100
VISION	ath. or: Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	tion	mm, Day 10a	.,		Yes 2□N	10				
<u>"</u>	r Atte er de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	20e. Piac	ce of injury - A	At home, farm, st	reet, factory, office		28	Bf. Location (S City or Tow		lumber or Rura	al Route Number,
5	ital o rs aft ral Di lled ir	Cer											
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 🔀 Certifying (Check only 2 Medical Ex	caminer: On the	ne best of my basis of exar Inner stated.	knowledge, deat mination and/or in	th occurred at the tire envestigation, in my o	me, date and opinion, deat	d place, ar th occurre	nd due to the d d at the time,	cause(s) an date and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	211			29c. Licens	e number			29d. Date s	signed (Month,	Day, Year)
	7.0		1 /lldeles	ller	- a			D24093				July 22,	2008
			30. Name and address of person wi	no completed cau	use of death ((Item 23a) (Type,	Print)						
			Mark Parkhurst, M.				Silver Spri	ing, Man	ryland	1 20904			
	Sta		31. Date filed (Month, Day, Year)	008	Registrar's S	signature	anti 1						
	Registr	ar	JUL 23 2	JUU AL	1450	J.J. 1879	100						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28f, pestate of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5,2008 JULY 2:40A LILLIAN JOANNA BURKE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES SOUTHERN MD. HOSP.CENTER CLINTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 □ F 89 213-40-7950 4-16-1919 WASH., D.C. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits X□Yes 2□No PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 MIKE SHAPIRO DRIVE 20735 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM S. SWEENEY EMMA BRUMLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILLIAM J.BURKE - SON WHITE PLAINS, MD. 20695 10536 DEACON RD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT.CEM. 7-17-08 ARLINGTON, VA. 21. Signature of Emeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. . RC LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rdiac Due to (or as a consequence of): Vetabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1□ Yes 2 NO 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

the death certificate be executed burial-transit and physician the burial Box 68760, as 1 attending for use a P.0. ed by the a detached for signed by t Records, certificate has been s rector, page 2 should Division or Vital After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in

marked other than

d 2 should be fi th and Mental F

1 and 2 st Health an

Pages 1. ent of Hea

Injury or permit. Page Department o Important: If any Injury or

Physician

/Medical

Examiner

Examine

Physician/Medical

þ

Completed

Certification:

Medical

within 72 hours after death

Maryland 21215-0036

Baltimore,

Director

Completed

1 Yes 2 No 27. Manner of Death 1 Natural

4 ☐ Homicide

25. Was case referred to medical

6 Could not be determined

Pl. ce of injury - At home, farm, street, factory, office building, etc. (Specify) home

28f. Location (Street and Number of Mike Shapiro Clinton, MD

29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA

mis

9/3/

scataway CLINTON

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY VERNON ROBERT CHRISTENSEN 21 2008 5:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERITAGE HARBOUR HEALTH CENTER ANNE ARUNDEL ANNAPOLIS 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 M 2 □ F if Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Year) Months 503-28-5286 Director JUNE 17, 1927 81 SOUTH DAKOTA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be i **7H OUEEN VICTORIA WAY** 21619 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: 1951-1953 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE RETAIL MANAGEMENT other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H item 27 is marked ott Be ို ROBERT CHRISTENSEN JULIA BOYD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at MARTIN CHRISTENSEN/SON 28 POULTNEY STREET, BALTIMORE, MARYLAND 21230 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town. State cemetery, crematory or other place CROWNSVILLE VETERANS CEMETERY important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State JULY 25 4 Donation 5 Other (Specify) CROWNSVILLE, MARYLAND 2008 21. Signature of Funery 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No has page 2 certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury at Work? Hospital or Attending 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide To the hosp.

within 24 hours after use.

To the Funeral Direct 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier timertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number 37936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Cherkey MD 21419 2108 (), 1) arch

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL

32. Registar's Signature

2008

			For State Registrar	State	of Marylar		artment of F			iene eg. No. 2008	25319
	· .	-	Decedent's Name (First, Middle)	fle, Last)					2. Date of Deat		3. Time of Death
4	Physicia	an	Alma Bertha Co	,					July 2	Day Year 1, 2008	4:55pm ^M
	/Medic		4a. Facility Name (If not institution		umber)		4h. City. Town, o	r Location of Deatl		4c. County of Dea	
År.	Examin	er	Wilson Health	, 0			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rsburg		Montgom	
7.5	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.		9. Bi	rthplace (State or Foreign
	Funeral Director	8	212-05-4655	1 ☐ M 2 🔀 F	100	Yrs.	Months Days	Hours Min.	(Month, Day,	, 1907 Mar	Country)
-	-	1	Usual Residence of Decedent		100				11011 20	, 1907 [1101) Iuliu
	ylanc sow		10a. State 10b. County	у	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mar Fled	ō	Maryland Monte	omerv	G	aithers	sburg				1 X Yes 2 □ No
	r 28g	Director	10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,			10f. Zip Code		1	0g. Citizen of What C	ountry?
	n with		301 Russell Av	enue #443	R.		20877			United St	ates
	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show kther then "dedical Examiner must be notified at	Funeral	11. Marital Status	12. Was De	ecedent Ever in U Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am Black, Wh	
ယ	after or ite	교	1 ☐ Never Married 2 ☐ Ma		2 [X No		1 ☐ Yes 2XINo	Specify:	to riicari, etc.)		
ğ	ral", c	þ	3 ☐ Widowed 4 ☑ Divorce	d Year or	Dates:		TLI Fes ZLACINO	эреспу.		Specify: Wh	ite
5-0036	72 hc natur lical	Completed		nt's Education est grade completed	1)	16a. Dece	dent's Usual Occup	ation during most of wo	rkina	16b. Kind of Business	s/Industry
2	e. an "	ם	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired tant Chie	d)	9	Telenhon	e Company
2	filed wi Hygien other th	် ဂ	10				ohone Ope	rator			- Company
Maryland 2121	should be filed within 72 hours after death with the Marylan od Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle	, Last)				18. Mother's Nar	me (First, Middle, I	Maiden Surname)	
<u>a</u>	should be and Mental smarked o	힏	George H. Cole	man			:	Caroli	ne G. Scl	hultz	
a	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailii	ng Address (Street	and Number or R	ural Route Number	r, City or Town, State,	Zip Code)
	1 and 1 Health em 27		Rev. Harold La	ınman(Pers				Avenue,			
S C	00		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	2 DRamaval fra		Place of Dispo cemetery, cre-	osition (Name of matory or other plac	ce)	Date	20c. Location - City of	r Town, State
Ĕ	Pages nent of I int: If its iry or o		4 □ Donation 5 □ Other (tropol:	itan Crem	atory 7/	22/08	Alexandria	, Virginia
altimore,	permit. Pag Department Important: I any Injury o	1	21. Signature of Funeral Service	elicensee		12	2. Name and Addre) East De aithersbu	ss of Facility De	Vol Funer	ral Home	
m	9		Cuetis	LA4		Ġ	aithersbu	rg, MD 2	0877		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications tha	t caused the dea	ath. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	C	nale	tin	e Rea	rtda	iluse	·	Onset and Death
)	/Medical		resulting in death)		o (or va conse			U		00000000000000000000000000000000000000	
5	Examiner			1	Like	ni	car	dion	myor.	ethy	
	2000	Je.	if any, leading to immediate cause. Enter Underlying	Due	o (or as a conse	quence of):		7	,00		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events		121	rac	yark	erza	used	u	
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8760,	ficate be executed physician and sthe burial-transit	dical		d				· · · · · · · · · · · · · · · · · · ·			
9	tificating physical as the	a									<u> </u>
Box	that the death certificed by the attending podetached for use as	N.	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregr e birth 2 ☐ Fe		⊒Ectopic pregnanc	v		23d. Date of d	•
	deat e atte	icia	in the past 12 manths? 1 □ Yes 2 ☑ No	4□Pre	gnant at time of		Other (specify)	у		Month	Day Year
0	t the by th ache	hys	9 Unknown	9□Un	known						
ري ت	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	by Physician/M	Part II. Other significant condit	tions contributing to					23e. Did to	bacco use contribute	to the cause of death?
Records,	quire en sig uld b	pa k	Diestalli	referen	reben	2.016	itrala	ud	1 □ Y	es 2☑No 3□I	Probably 4 □Unknown
ပ္တ	s bee	olet	Licerap	it he	icien	itate	in le	nel	24a. Was a		autopsy findings available
ď	siclan: The law s certificate has t irector, page 2 s	Completed	15.5.111:		10/21	Bul	cutio	20	autop: perfor 1∐ Yes	med2 death?	
Vita			25. Was case referred to medic	al	7	V			ath (Check only or		2 110
5	ysick s cer direct	To Be	examiner? 1 ☐ Yes, 2 ☑ No	Hospital:] Inpatient 2] ER/Outpatie	nt 3 DOA Oth			ence 6 □Other (Sp	necify)
Division or	a Ph er thi eral (T:U	27. Manner of Death		te of Injury	28b. Time o	of 28c. Inju-	ry at		ow injury occurred	
0	th. :: Aft	ıtioi	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ing (M tigation	onth, Day Year)	Injury		Yes 2 No			
<u>Vis</u>	Atte r dea ecto by th	ifica	3 Suicide 6 Could 4 Homicide deter	mined 200. Pla			reet, factory, office			treet and Number or	Rural Route Number,
ā	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	- Intimide	Du	ilding, etc. (Spec	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	n, Glaic/	
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	he Hi in 24 he Fi	Medical	one)		anner stated.	iauvii and/of If	ivestigation, in my	opinion, death occ	urred at the time, (date and place, and d	ue to the cause(s)
	To the withing To the Complex	M	29b. Signature and title of certifi	ier			29c. Licens			29d. Date signed (Mo	
	01		1 Rake	toice	chlev	- de	1 40	14115	5 8	July 2	1,2008
,	1		30. Name and address of perso	n who completed ca	ause of death (Ite	em 23a) (Type,	Print) e	20120	43582	LAVER 26, MS	TUE
			31. Date filed (Month, Day, Yea	BIRSC	HBAR	4, W	W.	CAITH	ERSBU.	e6, Ms	20877
	Sta	ite	31. Date filed (Month, Day, Yea	r) 32	egistrar's Sigr	nature	actil				
	Registi	ar	TH 2.5	3 2008 2	BUREA -	KI MER	100				

			For State AMENDHOGONARD 7	tate of Marylar	nd / Depa					000	25320
7	100		Territory For State RegistrarAMEND#26perMD, 7-2 1. Decedent's Name (First, Middle, Last)	3-08, HMW, MDCD	Cei	rtificate o	Death	2. Date of De	Reg. No. 2	000	3. Time of Death
	Physici /Medic		Roberto S. Conce	pcion				July	19	2008	4:30 P M
I	Examir		4a. Facility Name (If not institution, give street 10628 Muirfield D			4b. City, Towr	n, or Location of D	eath		nty of Death	
9.	Funeral	, j	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24		th	ontgome 9. Birthp	lace (State or Foreign
	Director		212-49-0000	2□F 62	Yrs.	Months Day	ys Hours N	Min. (Month, Da		Phil	ippines
	vand ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	e Man 3a-f sh tiffed	ctor	MD Montgomer	у	1	Potomac					1 □Yes 2 X No
	th with th 23a or 28 ust be no	al Director	10e. Street and Number 10628 Muirfield Dri	ve		10f. Zip Cod	20854		10g. Citizen d Unit	of What Cour ced Sta	•
30	be filed within 72 hours after death with the Maryland ttal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U Armed Forces? 1		Was Decedent of If Yes, specify C 1 X Yes 2 □ N		? (Specify Yes or No Puerto Rican, etc.) Filipino		Race - Americ Black, White, cify:	
212-0036	hin 72 hou e. In "natura Medical E	Completed I	15. Decedent's Educati (Specify only highest grade co	on	16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use rei	cupation ne during most of ired)	f working	16b. Kind of	Business/Ind	dustry
7	filed within Hygiene. ther than "	Com	12			Fabrica				eon Sig	gns
and	id be fi ental F ked ott Ic ever	To Be	17. Father's Name (First, Middle, Last) Abelardo Concepcio	n				Name <i>(First, Middle</i> alina Salı		iame)	
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked, any Injury or other traumatic ev once.	-	19a. Informant's Name/Relationship (Type. Emilia Concepcion/W					or Rural Route Numb			Code)
ore,	ges 1 at of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem		cemetery, crei	osition (Name of matory or other		Date 1 v 24	20c. Locatio	n - City or To	own, State
бант	artmen ortant: Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Me	cremat		dress of Facility	1 y 24 2008	Alexan	dria,	Virginia
ñ	Dep Imp any		TRACYA Stu					me, 10 Eas	st Deer 20877	Park	Drive,
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the dea ause on each line.	th. Do not ent	ter the mode of	dying, such as car	rdiac or respiratory a			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	namence of):	ngeal	cance	1	·		
	Examiner	_	Sequentially list conditions. b. —	mass r	TANT	temp	cance	be			Zmonth
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	Due to (or as a consec	quenge of):	1					
<u>5</u>	ficate be executed physician and sthe burial-transit	Еха	resulting in death) Last	Due to (or as a consec	quence of);						
28/20,	physici physici the bu	edical	d								
O. BOX C	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3[Ectopic pregna Other (specify				Date of delive	ery Day Year
7	s that the ned by detact	by Ph	Part II. Other significant conditions contrib	uting to death but not res	sulting in the น	nderlying cause	given in Part I.	23e. Did	tobacco use co	ontribute to the	ne cause of death?
	equire en sig ould be		meningiti	s, hyper-	ten 517	M		1	Yes 2 No	3 ☐ Prob	pably 4 □Unknown
vital Records	The ate has page	Completed						24a. Was auto perfo 1∐ Yes		b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	oital:	15D/0.4		Other:	Death (Check only	./		On or no e
0	ing Physical After this funeral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	" 3 DOA	4 ∐ Nursii njury at Vork?	ng Home 5 ARes 28d. Describe		Other (<i>Specif</i> curred	77-76-6
IVISION	tendlr leath. tor: Af the fur	catio	2 Accident investigation			M 1	☐Yes 2☐No				
2	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 ☐ Homicide determined 4	8e. Place of injury - At h building, etc. (Speci	ify)			City or To	wn, State)		il Route Number,
	e Hosp 24 hou e Fune letely fi	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my kn On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at th vestigation, in n	e time, date and p ny opinion, death	place, and due to the occurred at the time	cause(s) and , date and plac	manner as s ce, and due to	tated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	0		29c. Lic	ense number		29d. Date sig	ned (Month,	Day, Year)
)	10		Hohm Hu	- 78		MD	60658		7	21/08	·
			30. Name and address of person who comp	Heted cause of death (Ite			Connect	Teut An	re, k	ens in	tun 2089
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	actis				U	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ivial		rtificate of		Re	eg. No. 2008	25321	
-	Physicia		1. Decedent's Name (First, Middle Oliver	Woodland	Dashiell			2. Date of Death Month	h Day Year	3. Time of Death	
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution,	PICE AT TH	IE LAKE (In yrs. last birthday) 3 Yrs.	4b. City, Town, o	r Location of Death S U S If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8/13/19	Year) 9. Birth	n Co nplace (State or Foreign funtry) ryland	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wice	comico Salisb		ocation			10d. Inside City L 1 ⊠ Yes 2		
		al Direc	10e. Street and Number 609 N. Pinehu						10g. Citizen of What Country? USA		
		To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 XNo Specify:			No- 14. Race - American Indian, Black, White, etc. Specify: white		
		npieted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	(0-12) College (1-4or 5+)		cedent's Usual Occupation ve kind of work done during most of working DO NOT use retired) resident			J. Roland Dashiell & Sons, Inc.		
land 21		o Be Cor	17. Father's Name (First, Middle, J. Roland Dash		PL	esidenc	18. Mother's Name	(First, Middle, M Disharoo	Maiden Surname)		
			19a. Informant's Name/Relationsl Michael Dashi	ip (Type. Print) ell/son	19b. Maili 10 6	ng Address (Street Autumn I	and Number or Rura Lane, Frui	al Route Number tland, I	r, City or Town, State, 2 MD 21826	ip Code)	
Baltimore,		3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery 7/24/08 22. Name and Address of Facility Holloway Funeral Home Proceeds (Name of cemetery, crematory or other place) 22b. Place of Disposition (Name of cemetery, crematory or other place) 7/24/08						20c. Location - City or Town, State Salisbury, MD rofessional Association		
8	Physician /Medical Examiner	ledical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTR PRWAL INSUPPICIENC Due to (or as a consequence of): ASURATION PNRUMONIA								
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are deat. To the Funeral Circetor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	<i>V</i> / <i>V</i>					
Box		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specially)			etopic pregnancy ther (specify)			23d. Date of delivery Month Day Year	
rds, P.O		ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						obacco use contribute to the cause of death? Yes 2 7 9 9 10 10 10 10 10 10 10 10 10 10 10 10 10		
Vital Records,		Completed						24a. Was a autops perfor 1∐ Yes	an 24b. Were an prior to death?	utopsy findings available completion of cause of	
or Vita		To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:		III 3 DOA		ome 5 ☐ Resid	ne) ence 6 □Other (Spe ow injury occurred	ecify)	
Division or		Certification:	27. Manner of Death Actident S Pending investigation Suicide Albanicide Pending investigation Suicide Albanicide Pending investigation Suicide Albanicide Pending investigation Suicide Albanicide Pending investigation Suicide Albanicide Pending investigation Suicide Albanicide Suicide Pending investigation Suicide Pending investigation Suicide Pending investigation Suicide Pending investigation Pending							ural Route Number,	
		Medical Co	29a. Certifier Certifyir (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	pleted cause of death (Item 23a) (Type, Print) COASTAL HOSPICA P. BOX 17 33 SALIS BUMPLIE US 32. Figistrar's Signature 1. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 7/1 9 (c) SALIS BUMPLIE US 32. Figistrar's Signature						
	To th withir comp	Me	29b. Signature and title of certifie			29c. Licen	se number 005	0	29d. Date signed (<i>Mon</i>	th, Day, Year)	
	St		30. Name and address of person G Huth wAr 31. Date filed (Month, Day, Year)	who completed cause of de COAST	eath (Item 23a) (Type H H SA ar's Signature	Print)	P.U BOX	17 33	SALISB	имушь 2183	
	Regist	ar	00L N	1400	2 10 19	All Market					

DHMH 17 Rev 1/2001

DASHIELL, WOODY

08-05770 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Albert O. Dale State of Maryland / Department of Health and Mental Hygiene 2008 25322 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 28, 2008 1201 hrs Medical Examiner Albert O. Dale, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Hours Days Director 220-80-5227 Country) MD 1 X M 2 45 Dec 14, 1962 Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1x Yes 2 No Worcester MD Berlin hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country 102 Maple Avenue 21811 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 Nο Specify: Black f Yes, Give Year Army Yes 2 X No specify: Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. If item 27 is marked other than 12 n/a 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert O. Dale, Sr. Alice Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delvan V. Dale/wife 102 Maple Avenue, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State mportant: Paul's Cemetery 8/02/2008 Berlin, MD Donation 5 Other Specific 22 Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21. Signatur - Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medica Death Hypertensive cardiovascular disease Immediate Cause (Final disease ⊏xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and transi Physician/Medical AMENDED #1,23a,PII,27,perME, g882 8/14/08 TT the attending physician ted for use as the burial X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 ✓ No 3 Probably 4 Unknown End stage renal disease; diabetes mellitus; Completed of Vital Records, certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available hyperparathyroidism autopsy prior to completion of cause of death? performed? ✔ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes 2 After 27. Manner of Death 28a. Date of Injury (Month, Day,Yea 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division Pending Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

the Funeral Director:

DHMH 17 Rev 1/2001 OCME 2006

State Registra

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 29, 2008

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Tasha Greenberg MD.

31. Date filed (Many Cay Near)

	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2008 25									25323			
			1. Decedent's Name (First, Middle, Last) 2.						2. Date of De	e of Death 3. Time of De			
	Physici: /Medic		DR. NNAMDI A. DIKE				JULY			21 2008 1:00		1:00 A ^M	
	Examin	er	4a. Facility Name (If not institutio		imber)		4b. City, Town, or Location of Death			4c. County of Death PRINCE GEORGE S			
		35	6533 PARKWAY 5. Social Security Number	COURT 6. Sex	7. Age (In yrs	loct hirthday	HYATTSVILLE If Under 1 Year If Under 24 Hrs.		s. 8. Date of Bi			JEUKGE S	
	Funeral Director		165-42-6361	1.2XM 2□F	67	Yrs.	Months Days	Hours Mir	. (Month, D	ay, Year) 1 1941	Coui	entry) ERIA	
-	er ability sale		Usual Residence of Decedent		07				00112				
	how at		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 □ No	
	e Ma 3a-f s	cto	MD PRINC	E GEORGE T	S	HYATTS							
	sath with the s 23a or 23	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?	
		iral	6533 PARKWAY C		edent Ever in I	16 12	2078		Specify Ves or N	NIGER	LA ace - Americ	can Indian	
36	irs after de il", or item xaminer i	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed F	orces? 2[X]No	ł	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🏿 No		erto Rican, etc.)	BI	ack, White,	etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ted	15. Decedent's Education (Specify only highest grade completed) (Size kind of work done during more discounting more during					pation	orkina	16b. Kind of	. Kind of Business/Industry		
215		nple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)					Orking					
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Σ̈́			19a. Informant's Name/Relations			19b Mailii	na Address (Street				n. State. Zii	n Code)	
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ē,	f Hea f Hea item	- 39	20a. Method of Disposition		20b.	Place of Dispo	osition (Name of matory or other pla	ice)	Date	20c. Location	- City or T	own, State	
E G	Page nent o nt; If iry or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3		i Siaie		EMETERY	8/1	9/2008	ABIA, N	IGERI <i>A</i>	7	
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service	Licensee .	D		2. Name and Addre	•	J. B. J AD LANDO				
			23a. Part1. Enter the dise e, o shock, or heart failure. Lis	r complications that t only one cause on	caused the dea	ath. Do not en	ter the mode of dy	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between	
	Physician /Medical Examiner	23a. Part1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MALIGNANT NEOPLASM COLON UNSPECIFIED									Onset and Death		
			resulting in death)	Due to	b								
300			Sequentially list conditions,	b									
		nine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	}	o to (s) at a contecquation of).								
Ć,	cate be executed obysician and the burial-transit	Examiner	resulting in death) Last	cDue to	(or as a conse	equence of):							
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P.O. Box	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)						23d. Date of delivery Month Day Year			
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did	23e. Did tobacco use contribute to the cause of death?			
rds		q pa							_ 1 [1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown			
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r <	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 X No	Hospital: 1]Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ot	her: 4 🗆 Nursing	Home 5 🛣Res	sidence 6 □C	Other (Spec	ify)	
Division or	ng fter		27. Manner of Death 1X Natural 5 ☐ Pendi	/8.4-	e of Injury nth, Day Year)	28b. Time o Injury	Wo	ork?	28d. Describe	how injury occ	urred		
Sio	Attending r death. sctor: Afte by the fune		2 Accident investigation M 1 Yes 2 No 2 Accident Accident Suicide										
Σ	or Al after d Direc in by	ırtifi	4 Homicide deter	mined 26e. Plac built	ding, etc. (Spec	cify)	reet, factory, office			own, State)	riber or Hui	ral Route Number,	
ш	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce											
	the the the the the the the the the the		one) 29b. Signature and title of certifi		nner stated.		29c. Licen	se number		29d. Date sig	ned (Month	, Day, Year)	
										29d. Date signed (Month, Day, Year)			
	9	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						JULY 2	Y 22, 2008				
	DONA LESKUSKI M.D. 9200 BASIL COURT # 200 LARGO, MARYLAND 20774												
W	State Registrar 31. Data files (Manth Carro Year) 32. Registrar's St matures												

State of Maryland / Department of Health and Mental Hygier (2) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vasi **Physician** July 23, 2008 Calvin Vaughn Eddy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town, or Location of Death Examiner Hancock Washington 603 Quaker Creek Apartments If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours Min Yrs Director 86-24-7849 81 PA April 13, 1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County in than "naturel", or items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No PA Fulton Mercersburg **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 Tollgate Ridge Road 17236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. ģ 3 ☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than 8 Brick Mason Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be 1 and Mental i is marked Frank Brooks Eddy Reba Kathryn Weller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 is Connie Eddy/Daughter 425 Tollgate Ridge Road Mercersburg, PA 17236 Anit. Pages 1 a. Department of Health Important: If iter any Injury or Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Denation 5 ☐ Other (Specify) Antioch Christian 07/26/2008 Big Cove Tannery, PA 21. Signature of Juneral Service I consee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 that caused the death. Do not enter the mode of dying, such as use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caus rdiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequ Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has ral director, page 2 1 ☐ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) NOME Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide after To the Hospital within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) auc; Hageistown, nD 12821 Ahmed, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 6 2008 Registra

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4000	oeam	nera	11 Manital Status 12 Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cubi		pecify Yes or No)- 14. Ra	ce - America	n Indian,	
0	or ite	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give 3 Widowed 4 Divorced Year or Dates:	lo	1 ☐ Yes 2 X No	Specify:	o Rican, etc.)	Specia	ck, White, e		
	atural cal Ex		15. Decedent's Education	16a. De	ecedent's Usual Occup	ation		16b. Kind of E	DITW		
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	s I amous zenoulo be used within 72 nouns after death with the Marylar Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. other 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	,-	19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street			-			
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Hoonie	To the Propriat of Authoring Priyscant: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one) 1	examination and/o	eath occurred at the ti or investigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time	cause(s) and m , date and place	nanner as sta , and due to	ated. the cause(s)	
5	withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sign	ed (Month, L	Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $\mathtt{July}^{\mathtt{Month}}$ 19°, 2008 Ozelle Evans 2:06 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hyattsville Prince George's Heartland Health Care Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2**X** F 89 579-26-4512 Edgefield, S.C. Director 07/02/1919 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at YXYes 2 No Directo Md. P.G. Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be a 20785 U.S.A. 7801 Barlowe Road # 210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. African— 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ American 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Foster Grandparent P.G. County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Pixlev Naomi Chiles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2326 Houston St., Suitland, Maryland 20746 Carolyn Evans/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of H Important: If ite any Injury or ot once. 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 07/25/08 Suitland, Maryland 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee au N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ∣□Yes detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MSION 1 ☐ Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 2 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 🕅 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar HAMOVE

person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

Division of Vital Records, P.O. Box 68760,

1 - State Registrar

		1. Decedent's Name (First, Middle	e, Last)							2. Date of			00	3. Time	of Death
Physicia		Stephen Michael	1 Easter							July	21.	² 2008	Year	7:11	
/Medic		4a. Facility Name (If not institution		er)		4b. City	Town, or	Location	of Death	002)		ic. County	of Death	,	
Examin	ler	Montgomery Gene				40. Oity,	01n		i oi bealii			,	gomer	V	
Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. las	t birthday)	If Under		If Unde	r 24 Hrs.	8. Date of	Birth		9 Rirthol	ana (State	or Foreign
Director		214-60-5966	1⊠M 2□F	56	* * *	Months	Days	Hours	Min.	June	18 Yea	1952	Nort	h Car	olina
		Usual Residence of Decedent							1	i					
yłan how		10a. State 10b. County		10c. City, 7	Town or Lo	cation							10	d. Inside	City Limits
Mar a-f sl	to	Maryland Montgo	omery		Germa	ntow	a							1 □Ye	s 2 <mark>≹</mark> No
r 28	Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of W	hat Count	ry?	
h with	a D	23320 Ridge Roa	ad				208	76			Un:	ited S	State	S	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decede		13. \	Was Dece	dent of H	ispanic C	rigin? (Sp	ecify Yes or	No-		e - America		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be multised at once.		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	ng Address	(Street	and Num	ber or Rur	al Route Nur	nber, Cit	y or Town,	State, Zip	Code)	
and and n 27		William Craig I	Easter (Bro	ther)	3499	Adgat	e D	rive	, Ija	msvill	.e, 1	1D 217	754		
of H of H fitter		20a. Method of Disposition	0 T B	0.000	e of Disponetery, cren	sition (Nar	ne of ther plac	:e)	Ju1y	Date 22	20c.	Location -	City or Tov	vn, State	
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Examiner															
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outed id ansit	Ē	cause. Enter Underlying Cause (Discase of injury that initiated events											1		
exection and and and and and and and and and an	Ex	resulting in death) Last	Due to (or	as a consequer	nce of):										
te be ysicia e bui	cal		d												
tifica ig ph as th	cian/Medical Examiner														
andin use	7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor									23d. Dat	e of delive	ry	
deatle atte	icia	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnan	h 2□Fetal de it at time of dea		Dectopic pour less of the control of		у				Мо	nth I	Day	Year
t the by th ache	Physic	9 □ Unknown	9 Unknow	n											
s tha med e det	by P	Part II. Other significant condition			-		ause give	en in Part	i.	23e. Di	d tobacc	o use contr	ribute to the	e cause o	f death?
quire in sig	d b	Congestive Hear	rt Failure;	Renal	Failu	re;				1 [Yes	2 🕱 No	3 Proba	ably 4 [] Unknown
s bee	Completed	Adult Respirato	orv Distres	s Svndr	ome					24a. W	as an	24b. V	Vere autor	sv finding	ıs available
he la e ha:	Ĕ		<u>, </u>							au pe	topsy rformed	, F	orior to con death?	pletion of	cause of
ifficat		25. Was case referred to medical	ï								2 🔯	No 1	I□Yes	2 □ No	
ding Physician: The law h. After this certificate has funeral director, page 2 s) Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	otiont OFF	2/Outrotion		Oth	ar.		h (Check on					
Phy r this ral d	To	27. Manner of Death	28a. Date of I	atient 2 EF	3b. Time of)A	4 ⊔ Γ		ome 5 Re 28d. Describ)	
ding h. Afte fune	tio	1 Natural 5 Pendin	ig (Month,	Day, Year)	Injury	M	8c. Injur Worl 1 □	<br Yes 2[Log. Descrit		ijary occurr	Cu		
Atten deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could	not bo	Injury - At home	e. farm. stre					28f. Location	Stroot	and Numh	er or Rural	Route No	ımher
after Dire	Certification:	4 ☐ Homicide determ	building,	Injury - At home etc. (Specify)	., 941	, radioly	,			City or	Town, St	ate)	or or mural	, route NL	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 🗡 Certifvir	ng Physician: To the be	st of my knowle	edge death	1 Occurred	at the ti-	me date	and place	and due to	he cauc	o(e) and me	anner se c	ated	
24 hr 24 hr Fun etely	Medical	(Check only 2 Medical one)	Examiner: On the basis	s of examination	n and/or in	vestigation	, in my o	pinion, d	eath occur	red at the tin	ne, date	and place, a	and due to	the cause	e(s)
ithin o the	Mec	29b. Signature and title of certifie		otatou.		290	. Licens	e number			29d	Date signed	1 (Month 1	Jav. Yearl	
F ≥ F ŏ		La -		`		1	_,00110					0.91100	_ ,	,, .Jui)	

exandria, Virginia al Home, ersburg, MD 20877 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day use contribute to the cause of death? XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 6 ☐ Other (Specify) ry occurred nd Number or Rural Route Number,) and manner as stated. d place, and due to the cause(s) ite signed (Month, Day, Year) Vs. Liluie Hima - Hourson's D58542 July 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Libuse Heinz-Momcilovic, M.D., 10605 Concord St., #500, Kensington, MD 20895 32. registrar's Signature PARIAGE **ORIGINAL**

State

Registrar

31. Date filed (Month, Day, Year)

2008

		-	For State Registrar	State	f Marylan		artment of rtificate o				giene Reg. No.	800	253	28
	Physicia	an	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	Day	Year	3. Time of D	M
	/Medic	al	John Edmund	Ford	imbar)		4b. City, Town	or Location	of Death	July		2008 County of Deat	2:30 j	р "
	Examin	er	4a. Facility Name (If not institution Kensington Nu	_		enter		nsingt			-	ntqomer		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Ye	ar If Unde	er 24 Hrs.	8. Date of Birt (Month, Da	th	9. Birt	hplace (State or F untry)	Foreign
	Director		215-14-6101	X 1 X M 2□ F	86	Yrs.	World Cay					921 Mar	yland	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City	Limits
	Mary L-f ah	tor	Maryland M	ontgomery	,	Kens	ington						1 ☐ Yes 2	! 🔀 No
	or 28s	Directo	10e. Street and Number				10f. Zip Code	9			10g. Citiz	en of What Co	untry?	
	ath wi		3000 McComas				20895		No. 1 - 0 / 0	-7N-		SA 4. Race - Ame	riogn Indian	
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or tema 23a or 28a-f ahow event, fre Medical Eracilise mant be notified at	by Funeral	11. Marital Status 13 Never Married 2 Marria 3 Widowed 4 Divorced	ried Armed F ried tx Yes If Yes, G	2 🗀 No		Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☐ ★	uban, Mexic	an, Puerto F	city Yes or No Rican, etc.)		Black, Whit Specify:		
5-0036	72 hou	ted	15. Deceden (Specify only highe	t's Education	1	16a. Dece	dent's Usual Oci	cupation	ost of workin	na	16b. Kir	nd of Business	Industry (
2121	ithin 7	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use ret	rired)		.9				
S	filed w Hygier other th		17. Father's Name (First, Middle,	Last)		S	upervis		ther's Name	(First, Middle,			vernment	-
anc	ould be for Mental Hearked of	о Ве	John Ford	2401/						M. Ki		,		
aryland	ë D E E	ဥ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre	eet and Num				Town, State, 2	Zip Code) 20	0015
>	D = N =		James T. Reil	ly, Esq./		_	25 Wisc							DC
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 2006.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	cemetery, cre	osition (Name of matory or other) Heaven	olace)	Jul	y 24 2008		cation - City or ver Spr	Town, State	cylan
Balti	permit. Departn Imports any inju		21. Signature/of Funeral Service	1/4-		50	2 Name and Ad rancis O Unive	rsity	Blvd,	W, Si	lver		, MD 209	
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of	dying, such	as cardiac o	r respiratory a	rrest,		Approximate Interval Betwee Onset and De	een
	Physician /Medical		disease or condition resulting in death)	a	eimer's		se						unknov	m
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	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	mence of):								
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687	ficate physis the	ledical		d										
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 🗆 Live	utcome of pregn birth 2 Peta gnant at time of c nown	aldeath 3	⊒Ectopic pregna ⊒ Other (specify				2	23d. Date of de Month	,	ear .
P.0	hat the de of by the a detached		9 ☐ Unknown Part II. Other significant conditi	ons contributing to	death but not res	sulting in the I	underlying cause	given in Pa	rt I.	23e. Did t	tobacco u	se contribute t	o the cause of de	ath?
ds,	signed to det	d by	Dementia, Gast							10	Yes 2[□No 3 □ P	robably 4 🛣	nknown
Records,	w requir been si should	Completed	Failure To Thr					7		24a. Was		24b. Were a	utopsy findings a	vailable
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Viital	ilcian: Th certificate rector, pag	O	25. Was case referred to medica	u I				26. Pla	ace of Death	Check onl				
o <	y S	To B	examiner? 1 ☐ Yes 2 🔀 No		Inpatient 2		HIL 3 DOA					6 □Other (Spe	ecify)	
	ding Ph h. After th funeral	ion:	27. Manner of Death 1 XNatural 5 ☐ Pendi	ng (Mo	e of Injury nth, Day Year)	28b. Time o Injury	,	njury at Work? 1 □ Yes 2		28d. Describe	how injur	y occurred		
Division	tor:	Certification;	2 Accident invest 3 Suicide 6 Could 4 Homicide detern	nined 200. Flat	ce of Injury - At h ding, etc. (Speci					28f. Location (City or To			lural Route Numb)er,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or i	th occurred at th	e time, date ny opinion, d	and place, a death occurre	and due to the ed at the time,	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)	
	To the I within 2. To the I complet	Med	29b. Signature and title of certific	ər				ense numbe	er er		29d. Dat	te signed (Mon		
)	1		· C	howd	ny	/) D4	3121				July 2	2, 2008	
1	5+1		30. Name and address of persor Nurul Chowdhu	who completed ca				rtons	ville,	MD 20	866			
	Sta Regist		31. Date filed (Month, Day, Year	2008	Registrar's Sign	ature	all p							

DHMH 17 Rev 1/2001

State

Registrar

122 Speer Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2008

M.D.

. Registrar's Signature

Helen A. Noble,

AUG -

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07/29/2008 **Physician** 9:45 P M Johanna Mia Gibbons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2718 Luthy Rd. Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 T 74 03/07/1934 214-48-6395 Director Netherlands Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location rral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 2718 Luthy Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Ao If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) 12 Health Claims Examiner Insurance 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Servatius Hubertus Luyten Maria Hurbertina Frissen ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2718 Luthy Rd., Cambridge, MD 21613 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Bernard David Gibbons, Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Termation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Mid Shore Cremation Center 07/30/2008 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muse a Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician adenocarcinomo 2 months 1365TAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the i and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408B M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG -

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2008

08-05844 Joyce Graham Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 25331 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 28, 2008 1222 hrs Medical Examiner JOYCE ANN GRAHAM 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Civista Medical Center La Plata Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours MD Try) Director 218-82-0110 1-17-1960 48 M 2 X F Yrs Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Md. CHARLES HUGHESVILLE 1 Yes 2 X No or 28a-f show notified at once, Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country P.O.BOX 280 20637 U.S.A. or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, þ Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Marrier must 2 X No Yes Specify: BLACK Widowed Yes, Give Year 4 XDivorced Yes 2 X No specify: "natural", ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 henn of Health and Mental Hygiene.
ant: If item 27 is marked other than "r College (1-4 or 5+) 27 is marked other than " matic event, the Medical 21215-0036 HOMEMAKER OWN HOME 10 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) JAMES LEE TAFT Be MARY CATHLEEN SEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B STARLET GRAHAM-DAUGHTER 22824 AQUASCO RD. AQUASCO, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, other crematory or other place) Burial 2 X Cremation 3 Department of Important: I METROPOLITAN CREMATORY 8-2-08 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facilit RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Cardiac arrhythmia associated with ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and AMENDED 23a, PII, 27, perME, G884 10/7/08 TT physician the burial -X UNPENDED Physician/Med Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending led by the attending detached for use as Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b ò Yes 2 No 3 Probably 4 ✔ Unknown Seizure disorder Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital funeral director, Be examiner? Hospital: Other₄ DOA this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 ဥ 1 ✔ Yes No 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Division Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 31, 2008 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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			1 - State of Maryland / Department	artment of Hea rtificate of De	alth and Me eath	ntal Hygie	ene200	3 25332
ħ.			Decedent's Name (First, Middle, Last)			Date of Death		3. Time of Death
	Physicia		George Michael Hunt		ŀ	Month July	Day Yea 2008	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc		July	4c. County of De	
	Examini	eı	447 Post Road	Rising			Cec	i 1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8.	Date of Birth		Birthplace (State or Foreign Country)
	Director		216-84-7836 ¹ X M 2□F 44 Yrs.	Months Days H	lours Min.	(Month, Day, Y ar. 20,		ennsylvania
de	D		Usual Residence of Decedent					
	rylan how at	_	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma la-f s tiflec	cto	Maryland Cecil Risin	g Sun				1 ☐ Yes 2 🕅 No
	ith the	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What	Country?
	23a ust b	ral	447 Post Road	21911			USA	
	tems term	Funeral		Was Decedent of Hispa If Yes, specify Cuban, N	inic Origin? (Specif Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
36	s afte		1 X Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No S	pecify:		Specify:	White
Ö	hour tural	Completed by		dent's Usual Occupation	n	16	6b. Kind of Busine	
<u> </u>	n 72 i "na ledic	lete	(Specify only highest grade completed) (Give	kind of work done durir DO NOT use retired)	ng most of working		55. Tuna 01 Baomio	, madd y
7	with iene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+)	rmer			Agricul	ture
ō	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	18.	. Mother's Name (F	irst, Middle, Ma	aiden Surname)	
Maryland 21215-0036	lenta lenta rked ic ev	To B	George Albert Hunt	į	Margaret	Cliffo	rd	
ar.	shor ind N mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and	Number or Rural F	Route Number, (City or Town, State	e, Zip Code)
Σ	alth a		Margaret Hunt/Mother 44	7 Post Road	, Rising	Sun, M	D 21911	
J.	of He Item		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Dat	e 20	Oc. Location - City	or Town, State
Ĕ	Page nent o		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hopewell	Cemetery	7-30-	2008 P	ort Depos	sit, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Licensee	2. Name and Address o T. Foard	Facility Funeral	Home, P	.A.	
	TO 2 6 0		Tichard L. torque 1	ll S. Queen	Street,	Rising	Sun, MD	21911 Approximate
			23a. Party. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only or e ause on each line.	ter the mode of dying, s	den as cardiac or r	espiratory arres	il,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	vlov Acci	dent			Iday
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В		<u>.</u>	Se uentially list conditions if any, leading to immediate b. Due to (or as a consequence of).	Mill Chick	utea v	Wellitis	•	-
	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	Cili				
	al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	7200-				
8760,	cate be executed physician and the burial-transit	dical	d					
9	ificate g phy as the	edic	V					
ŏ	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	☐Ectopic pregnancy			23d. Date of	delivery
Records, P.O. Box	deatl e atte	icia	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5[Dectopic pregnancy Other (specify)			Month	Day Year
Ö	tt the by th tache	hys	9 ☐ Unknown					·
Ś	as the	by F	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given i	n Part I.			e to the cause of death?
ğ	w require been signature	ed				1 ☐ Yes	2 □ No 3 🗹	Probably 4 ☐Unknown
သူ	aw requast been 2 should	Completed				24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
ř	The lav	mo.				perform	ed? death	i? 'es 2□No
ita	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26	S. Place of Death (
5	nysic lis ce direc	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other:	4 ☐ Nursing Home	5 Residen	ice 6 DOther (S	pecify)
Division or Vital	iding Physician: th. After this certifications	Ë	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Injury)	of 28c. Injury at Work?	28	d. Describe hov	v injury occurred	-
<u>S</u>	endl sath. or: A	atic	2 Accident investigation		2 □ No			
Ë	pr Att ter de lirect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28	 Location (Street) City or Town, 	eet and Number or State)	Rural Route Number,
	urs af	Se						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, dea (2 │ Medical Examiner: On the basis of examination and/or in and manner stated.					
	o the o the omple	Mec	29b. Signature and title of certifier	29c. License nu	umber	29	d. Date signed (Me	onth, Day, Year)
	⊢≯⊢ŏ		I have her Anna	2004	14373			2008
•	_		30. Name and address of person who completed cause of death (Item 23a) (Type,				1 1 - 3	
	2			lonial Way,	Rising	Sup. MD	21911	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	✓ .	KTSTHE	Juli HD		
	Regist		31. Date filed (Month, Day, Year) JUL 2 4 2008	$\boldsymbol{\nu}$				

20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🔀 Removal from State Aug. Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Arlington, Virginia

Francis J. Collins Funeral Home Inc. of Funeral Service License 21. Signatur

500 University Blvd W, Silver Spring, MD 20901

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease

Approximate Interval Between Onset and Death years

Year

Due to (or as a consequence of) Type II Diabetes Mellitus Sequentially list conditions, Oue to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

23c. if yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 Other (specify)

23d. Date of delivery 3 Ectopic pregnancy Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Valvular Heart Disease,

1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown 24a. Was an autopsy

23e. Did tobacco use contribute to the cause of death?

July 22, 2008

Peripheral Vascular Disease

24b. Were autopsy findings available prior to completion of cause of death? performe 1 □ Yes 2 □ No 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

VA010105009

1 Yes 2 x x	lo	Hospit	tal: 1 ☐ Inpatient	2 🗆] ER/Outpatient	3 □ 1	OOA	Other:	4 🗌 Nursing H	ome	5 X Residence	6 ☐ Other	(Specify)
27. Manner of Death 1 Natural 2 Accident		28	Ba. Date of Injury (Month, Day, Ye		28b. Time of Injury	M		Injury at Work?	2 🗆 No	28d.	Describe how inj	ury occurred	İ

6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Bethesda Naval) Kenneth G. Pugh, MD 8901 Wisconsin Avenue, Bethesda, MD 20889

State Registrar

Physician

Funeral

Director

28a-f show

ō

"natural", or items 23a

oe filed wn. **al Hygiene. `⊶r than "r

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainments.

Physician

/Medical

Examiner

and buriat-tran

the as

signed I

page 2 s

funeral

I Director: A

filled in by

Box 68760,

P.O.

Records,

Division of Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Examine

Physician/Medical

ð

Completed

Be

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

Baltimore, Maryland 21215-0036

Injury or other traumatic event, the Medical Examiner must be notified at

/Medical

31. Date filed (Month, Day, Year)

23 2008



State of Maryland / Department of Health and Mental Hygiene 2008 25334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** 5:37a [™] Marion Elaine Jackson July 26. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrest Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 23, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Yrs. 72 June 1936 Iowa Director 483-38-1261 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shoving Medical Evanings must be notified at 1

Yes 2

No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 21234 USA by Funeral 8810 Walther Blvd. Apt 1006 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 255No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ➡ No Specify: ^{Specify:} White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be ဂ Charles E. Burlingham Velta Bossuot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8810 Walther Blvd. Apt. 1006, Parkville, MD 21234 Willis F. Jackson (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co. 7/28/2008 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Tarring-Cargo Funeral Home, P.A. 18 Lesson 23a. Part 1. Enter the disease, or conflications the caused the shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, HAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 ☐ Yes 2 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death
Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death completely filled in by the 1 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 24 hours a 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

555 W. Towsentown Blid Dendock Rigurian ermy 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

P.O. I

Records,

of Vital

Division

			_		Ce.	rtificate of	Dealli	лептат пуд в	eg. No.		
	Physicia	an	1. Decedent's Name (First, Middle,	Last)				Date of Deat Month	th Day Ye		
Aug.	/Medic	al	Maria Josephin	e Kilduff		l		08	02 200		
	Examin	er	4a. Facility Name (If not institution,	,			r Location of Death	and.	4c. County of D		
F	uneral		Stella Maris Ho 5. Social Security Number	Sex 7. Agu	e (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day)	Baltin	Birthplace (State or Foreign Country)	
	rector		219-18-1296	1□ M 2ÅF	84 Yrs.	Months Days	Hours Min.	08/03/1	1923 V	Virginia	
land	ow #		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
Mary	a-f sh	tor	MD Baltin	more	Timonium	n				1 □ Yes 2 📉 No	
h the	or 28a	Director	10e. Street and Number	INOT	TIMOMITUM	10f. Zip Code		1	0g. Citizen of What	Country?	
th wit	23a (ra L	2300 Dulaney Va	alley Road	_	2109	3		U.S.A.		
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examination must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	If Yes, Give	No I	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.	
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hydiene.	itural"	ed b	3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a. Dece	dent's Usual Occup	nation		16b. Kind of Busine	White	
215 27 nic 2	in "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of work	ing	Too, King or Edding	oo, maaday	
21. d with	er the	Com	12	College (1-40) 3		chboard O	perator	5	Stella Mai	cis Hospice	
ind be file	d oth event	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, I	Maiden Surname)		
arylan should be	narke natic	유	Thomas Blick		1		Anna Mu				
Mar d 2 sho	traur		19a. Informant's Name/Relationshi Gregory M. Kile		ļ	,	and Number or Rur Lane - Ki			, ,	
	item other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre				20c. Location - City		
Pages	int: If		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		1		i	4/2008 E	Baltimore.	, Maryland	
Baltimore, permit. Pages 1 ar	Importa any Inju once.		21. Signature of Funeral Service L	icensee	2	2. Name and Addre		F. Lass	sahn Funei	ral Home, P.A.	
	-		23a. Part 1. Enter the disease, or of shock, or heart failure. List of	omplications that caused	I the death. Do not en	ter the mode of dyi	ng_such as cardiac	or respiratory arr	rest,	Approximate	
	sician		Immediate Cause (Final disease or condition	-8 21	12/5/3	35 /	rkins	OFE !	LA Einas	Onset and Death	
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DHMH 17 Rev 1/2001

6:30 A.M.

AUGUST 2, 2008

KILDUFF, MARIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ам Walter Hewson Kitts July /Medical 20 2008 3:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1**√**□ M 2 □ F Months Days Hours Director 577-38-9022 25. 1911 West Virginia Oct. Usual Residence of Decedent 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 TYes 2 □ No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Merwood Drive Funeral 20912 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify: 9 Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Walter Kitts traumatic ၉ Ella Hewson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. Robert W. Kitts/Son 14009 Overton Lane, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State July 25, 4 Donation 5 Dother (Specify) Parklawn Memorial Park Memoria: Name and Address of Facility

Trancis J. Collins Funeral Home Spring, MD 20

On University Blvd, W., Silver Spring, MD 20

Approximate Interval Between Onset and Death 2008 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Immediate Cause (Final 0 **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): physiclan Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 II Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ronaru 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 1 ☐Yes 2 ☐No 2 X No or Attending Physician: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2<mark>X</mark> No Hospital: Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1-X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 CAccident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

of Vital Records, To the Hospital within 24 hours a To the Funeral C

Box 68760.

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State Registrar

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

Ata Motamedi,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25337

		1- For State Registrar		ficate of Death		Reg. N	2 U C	0 2000
Physicia edical Exami	ın/	1. Decedent's Name (First, Middle,Last) Chloe Ann Kline				Date of Death Month Da	y Year	3. Time of Death 1346 hrs
euicai Examii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or		uly 28, 2008	4c. County of Death	
		Washington County Hospital		Hagerstown		W.	Washington	
Funeral Director		220-77-5791 1_M 2XF	ge (In yrs. last	birthday) If Under 1 Year Months Days	11	Date of Birth(MApril 5	M/DD/YYYY) 9. Bir Foreig , 2007 Co	
any	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	ъ	Md. Frederick		Smithsburg				1 Yes 2XX No
the Maryl 3a or 28a-f	Director	10e. Street and Number 13224 Loy Wolfe Rd.		10f. Zip Code 217	783	10g. (Citizen of What Could	ntry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XX Never Married 2 Married Armed Forces 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year		13. Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto Ric		White, etc.	can Indian, Black, hite
urs afte	d b	15. Decedent's Education (Specify only highest grade con	mpleted) 1	6a. Decedent's Usual Occupat	ion (Give kind of work		Specify: b. Kind of Business/:	ndustry
036 thin 72 ho ne. r than "na Indical Ex	mpleted	Elementary/Secondary (0-12) College (1-4 or N/A	5+)	during most of working life. N/A	. DO NOT use retired))	N/A	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Timmy L. Kline			18. M other's Na me (Fi L i nd a	rst, Middle, Maid M. Rob		
MD 21 id 2 should alth and Me in 27 is ma aumatic ev	2	19a. Informant's Name/Relationship (Type, Print) Timmy L. Kline (Father)		19b. Mailing Address (Stree	lfe Rď. Sm	ithsbur	g,Md. 217	83
Baltimore, permit Pages I an Department of Hea Important: If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from S 4 Donation 5 Other Specify:	tate Garef	ace of Disposition (Name of cer Patony ar other place) 10 dist Church (Aug.	2,	Oc. Location - City or Garfield	·
Balt permit Departr Import injury		21. Signature of Funeral Service Licensee	MO141	J.L. Davis	Funeral			ury, Ave. Md., 21783
Physician /Medical	8 6	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.		Do not enter the mode of dying,	such as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
[™] "xaminer		Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a constitution)						1
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):					
uted nd ransit		events resulting in death) Last Due to (or as a const						
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 23	sa,27,2	28a-f, perME,	g882 8/22/	/08 TT		
ox 68 ath certifi attending	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcomes a substitute of the past 12 months? 23c. If yes, outcomes a substitute of the past 12 months? 23c. If yes, outcomes a substitute of the past 12 months are substituted in the	ome of pregna	2 Fetal death 3	Ectopic pregnance	у	23d. Date of deliver Month	y Day Year
P.O. Bees that the degree by the dedetached f	by Phys	Part II. Other significant conditions contributing to dea	th but not res	ulting in the underlying cause of	given in Part I.			the cause of death?
Cords, P.O. law requires that the has been signed by to should be detached.	ompleted					24a. Was an autopsy performe	24b. Were a prior to	utopsy findings available completion of cause of
ician: The law ccertificate has rector, page 2 sl	ပ	25. Was case referred to medical		26 Plans	e of Death (Check onl	1 Yes 2	No 1 ✓ Y	es 2 No
Vital hysician this cert	o Be	examiner?	ent 2 🗸 E	ER/Outpatient 3 DOA	Other: Nursing H		sidence 6 Othe	эг:
ion of tending Pheath.	H-1	27. Manner of Death 28a. Date of In (Month, Day,	Year)			ad. Describe how	drowned	
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should the	Certification:	3 Suicide 6 Could not be 28e. Place of I	njury - At hom	ne, farm, street, factory, office to ng pool		Bf. Location (Stree or Town, State mithsbu	et and Number or Re) 13224 La	ural Route Number, City
To the Hospi within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 2 Medical Examiner: On the basis of examt manner stated	amination and		ate and place, and du	ue to the cause(s) and manner as sta	
F % F 8	Me	29b. Signature and title of certifier		29c. Licens O.C.	00115		9d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who completed cause of Theodore M. King, Jr., MD. Assistant I		, and a second	reet, Baltimore,	MD 21201		-
St	ate		ar's Signature			21201		

State of Maryland / Department of Health and Mental Hygiene $2\ 0\ 8$

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4	J	J	J	(

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Physician	
/Medical	
Examine	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Marical Exemination is to notified at angles.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	ai yiai ia		tificate of L			Reg. No.	20330
	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
an cal	Donna	Jean	La	ansdowne		July	27 200	M
er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death		4c. County of I	Death
	Frederick Memorial Hospit	al		Freder	ick		Frede	rick
	5. Social Security Number 214-46-5054 Usual Residence of Decedent	e (In yrs. las 61	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da July 9	th 9.	Birthplace (State or Foreign Country) Maryland
	10a. State 10b. County	10c. City,	Town or Loc	eation				10d. Inside City Limits
5	Maryland Frederick		Fred	lerick				1 StYes 2 □ No
P C	10e. Street and Number		1,160	10f. Zip Code			10g. Citizen of Wha	at Country?
	238 East Seventh Street				701		United S	
era		Ever in I.I.S.	13 V			poify Voc or No		American Indian,
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, V	White, etc. White
pletec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		16a. Deced (Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation furing most of work)	ing	16b. Kind of Busin	ess/Industry
E E	7)+)	Hom	e Maker			Own Ho	ome
Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surname)	
To B	Walter L. Andrews				Mary	Fogle		
-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or Town, Sta	ate, Zip Code)
N 3	Brian Scott Lansdowne / Son		238	East Seven	th Street.	Frederick	c. Maryland	21701
1	20a. Method of Disposition	20b. Plac		sition (Name of natory or other place		Date	20c. Location - Cit	
	1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		thsburg	Cremaotry	200	8		, Maryland
	21. Signature of Funeral Service Licensee	M01433			ss of Facility sford P.A. urch Street		Home ick, Marylan	nd 21701
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cau on each li Immediate Cause (Final disease or condition resulting in death)	ne.	Feil		g, such as cardiac to R1			Approximate Interval Between Onset and Death
	Due to (or as	a conserve	nce ot):					1 Wreak
ner	Sequentially list conditions, it airs, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a conseque	nce of).					
ani	Cause (Disease or injury that initiated events	4						yers
Ä	resulting in death) Last Due to (or as	a conseque	nce of):					0
ca	d							
led	IF FEMALE.							
an/N	IF FEMALE: 23b. Was decedent pregnant in the pact 12 months? 23c. If yes, outcome			Ectopic pregnanc	v.		23d. Date of	
Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)			Month	n Day Year
y P	Part II. Other significant conditions contributing to death b		ing in the un	iderlying cause give	en in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
D P	Merrostand Avenipath	7_				1 🗆	Yes 2□No 3[☐ Probably 4 Shiknown
ete	Hu centros con	0				24a. Was	an 24b. We	re autopsy findings available
Completed by	-,),					auto perfo 1 ☐ Yes	ormed? dea	or to completion of cause of ath?]Yes 2 □ No
Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)	
မ		ent 2 E			4 LI Nursing H		idence 6 Other	(Specify)
tion:	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation 28a. Date of Inju (Month, Date)	ıry 2 ıy, Year) 2	8b. Time of Injury	28c. Injur Work M 1 🗆	yat <br Yes 2 □No	28d. Describe	how injury occurred	
ertifica	3 ☐ Suicide 6 ☐ Could not be	jury - At hom tc. <i>(Specify)</i>	ie, farm, stre	eet, factory, office	_		Street and Number wn, State)	or Rural Route Number,
Medical Certification:	29a. Certifier 1 Sertifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and manner st	of examination	ledge, death on and/or inv	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	e cause(s) and mann, date and place, and	ner as stated. If due to the cause(s)
Ř	29b. Signature and title of certifier			29c. Licens	e number 14,248		29d. Date signed (//	Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
		`	, , , , ,	,	ick, Maryla	and 21701		
te		rar's Signatu		,	,j I			
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Sta Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

			For State Registrar		y	Cei	tificate of		F	Reg. No.	2008	25339
В	Disselat		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month		Year	3. Time of Death
3	Physici /Medic	100	Robert Andrew	Lassen					July 25		008	6:00p ^M
	Examin		4a. Facility Name (If not institution, g.	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, o	r Location of Dea			County of Death	
	, v		103 South Roger				Aberde		.,		Marford	
	Funeral Director		044-28-1618	Sex 11 M 2□F	72	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		23°,	100 COUI	place (State or Foreign ntry) onnecticut
	land ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				1	IOd. Inside City Limits
	Mary -f sho ied a	호	Maryland Harford	٦	Δh	erde	an a					1 XYes 2 No
	r 28a	Director	10e. Street and Number		110	CLUC	10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	h witl 23a o st be	a D	103 South Rogers	s Street			210	001			USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.			Specify Yes or No- erto Rican, etc.)	. 1	4. Race - Americ Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	ty⊒Yes 2 □ I If Yes, Give Year or Dates:	1953-		I∐Yes 2√23 No	Specify:	,			ite
2-0	72 h 'natu dical	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	10	(Give	lent's Usual Occup kind of work done	durina most of w	orking	16b. Kin	d of Business/In	dustry
12	vithin nne. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retire	,		_		
	Hygie Hygie ther t	ပိ	12 17. Father's Name (<i>First, Middle, Las</i>	2	1	_tns	urance Bi		ame (First, Middle,		surance	
Maryland	d be tental	o Be							e Alice A		*	
2	shoul nd Me mark mati	ပ္	<u>Lawrence Andrew</u> 19a. Informant's Name/Relationship		1	19b. Mailir	g Address (Street		Rural Route Numbe			Code)
Š	and 2 saith ai		James R. Lassen	(son)			Coyote (ngdon, MD			,
ē,	s 1 and Head Item		20a. Method of Disposition	• • • • • • • • • • • • • • • • • • • •	20b. Place	of Dispo	sition (Name of natory or other place	1	Date		cation - City or To	own, State
altimore,	Pages nent of I int: if ite		Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		1		esbyteria		y 29, 08	Aber	deen, M	aryland
Balti	permit. Departrimports any inju		21. Signature of Funeral Servi Aic	MAN/NGO	cespe	22	. Name and Addre	ss of Facility T	arring-Ca	rgo 3399	Funeral	Home, P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. D	o not ent	er the mode of dyin	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		tEM.		HEAL	RT C	DISEAL	E		Onset and Death
	Examiner		Sequentially list conditions	b								
	Po #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопвециых	de of):						
	ecute and -trans	каш	that initiated events resulting in death) Last	c Due to (or as		no of:						
68760,	rtificate be executed og physician and as the burial-transit			Duc to (or as	a consequent	00 01).						
387	ficate phys s the	Medical		d				· - ·				
Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal de	ath 3[Ectopic pregnanc Other (specify)	/		2.	3d. Date of delive	ery Day Year
P.0.	t the c by the ached	hysi	9 Unknown	9□ Unknown								
	law requires that the death ce as been signed by the attendi 2 should be detached for use	by	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause giv	en in Part I.		bacco us ′es 2□		he cause of death?
00	aw requir s been si s should	Completed							24a. Was a	an	24b. Were auto	ppsy findings available
Ä	The la	mo							- autop	rmed? 2 No	death?	mpletion of cause of 2□ No
ta	lan: rtifica stor, p	Be C	25. Was case referred to medical					26. Place of D	1 Yes eath (Check only o		TUTES	2010
>	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/	Outpatier	t 3□ DOA Oth	er: 4 \(\sum \) Nursing	Home 5 Resid	lence 6	□Other (Specia	5y)
o uo	nding Pt th. :: After the funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da		b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury	occurred	
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	e Hospit. 124 hours e Funera letely fille	edical C	29a. Certifier Check only one) Certifying F	Physician: To the best aminer: On the basis o and manner sta	f examination	dge, deati and/or in	n occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ce, and due to the courred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
	To th Within To th	Me	29b. Signature and title of partifier	2 N	^		29c. Licens	/			e signed (Month,	
			11/1/	211			D54	756		JUI	Y 28	2008 MOZITO
			30. Name and address of person wh	o completed cause of d	-	a) (Type,	Print)			-	1	
			Robert Rapp,	n.D. 202	Pula	ukil	tighway,	Suite :	203, Hau	ire D	e Grace	MOZITTE
	Staچ Registr	_	31. Date filed (Month, Day Year)	2008 32. Registr	ar's Signature	83	Backe		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dimitriz Merri weather Jr 7:57 PM harles 2008 O 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Medical Center 4nnapolis Arundel 4nne If Under 1 Year | If Under 24 Hrs. | 8. | Months | Days | Hours | Min 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 29 Director none Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours etter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examinating must be notified at 1/XYes 2 ☐ No Funeral Director rince Georges District 10e. Street and Number 10g. Citizen of What Country? United States 8209 20747 ane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dimitriz Merriweather, Sr. Martine rinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Dimitriz Merriweather, Sr (father) District Heights, MD 20747 \$209 Laura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brentwood MD 20722 7/26/2008 Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee Funeral 22. Name and Address of Facility Fort Lincoln Mon it 3401 Blodensburg 1 sechant Brentwood, MD Rd 20722 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ematurit 1529min disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) been signed by the ettending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 2010 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an **Director:** After this certificate has in by the funeral director, page 2. autopsy 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 60 f Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident hours after deat ineral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely tilled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 00 Go 140 moleted cause of death (Item 23a) (Type, Print) Rogers 2001 Medical PKWY Annapolis . Md 21401 State

Registrar DHMH 17 Rev 1/2001

Margrabe

State Registrar

31. Date filed (Month. Dav. Year) AUG -2008

Khalid Waseem M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





			T- State of Maryland / I	Depa	rtment of Health and tificate of Death			25343
	-		Decedent's Name (First, Middle, Last)	001	incate of Beath	2. Date of Death	g. No.	3. Time of Death
	Physici		William L. Miller			Month 7	Day Year	0535 M
Total .	/Medio Examin		4a. Facility Name (If not institution, give street and number)	Ţ	4b. City, Town, or Location of Deat		4c. County of Deatl	
Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan			Peninsula Hospital	İ	Salisbury		Wicomi	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday)	If Under 1 Year If Under 24 Hrs		9 Birtl	place (State or Foreign
и	Director		214-54-1548 11ŽM 2□F 58	Yrs.	Months Days Hours Min.	Dec 6,	1949 Mar	intry) Vland
	pu w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow					
	sho	5	MD		nsburg			10d. Inside City Limits 1X Yes 2 □ No
	28a-1	ect	Wicomico Pd 10e. Street and Number		10f. Zip Code	10	0111	
	with ka or		32290 Long Ridge Road		21849	10	g. Citizen of What Co USA	intry ?
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. W		Specify Yes or No-	14. Race - Amer	ican Indian
ယ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ant, the Medical Exeminer must be notified at	Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		Vas Decedent of Hispanic Origin? (\$ Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
21215-0036	al", o	by	3 Widowed 4 Divorced If Yes, Give Year or Dates 1969–1976	1	☐Yes 2☐No Specify:		Specify: Wh	nite
5-0	72 hc natu	Completed			ent's Usual Occupation kind of work done during most of wo	rking	6b. Kind of Business/I	ndustry
7	ithin ne.	큠	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired)			
7	lygieu It, In	ပ္ပ	1	C	arpenter		Private	Industry
anc	be fill half half half half half half half ha	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	,	
Ë	d Med narke	ပ္	Robert Lewis Miller		-	Jane W		
Maryland	d 2 st th an 7 is r traur				Address (Street and Number or R			
	1 and Heal em 2		Richard L. Miller/Brother 59	9 Z 5	Dunbar Terrac		Oury, MD Oc. Location - City or T	21804
õ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State Howar	a crem	niversity :		•	
altimore,	artme ortan Injur		4 ☑ Donation 5 ☐ Other (Specify) Medic 21. Signature of Funeral Service Licensee	al	School Jul	. 18,08 W	ashingto	n, DC
Ba	Dep and		The organization of the or	3.8	Name and Address of FacilityAus 21 14th Street	STIN ROY	ster Fun	erai Home
			23x Pmm. En er trie dis ase, or complications that caused the death. Do					Approximate
	Physician		Immediate Carrie (Final		T 1			Interval Between Onset and Death
	/Medical		disease or con ition resulting in death) a. Due to (or as a consequence	off:	1 to taret	1		6 days
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	p ±	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):		Chiltha		() []
	ecute Ind transi	Examiner	Cause. Enter Uncertying Cause (Disease or injury that initiated events c	ve_	Heart Fe	.lure		6 day
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			IF FEMALE: 23c. If yes, outcome of pregnancy					
Box	atten for us	ian	in the past 12 months?		Ectopic pregnancy		23d. Date of deli Month	very Day Year
o.	law requires that the death certil as been signed by the attending 2 should be detached for use as	Physician/M	1 □Yes 2 No 4 □ Pregnant at time of death 9 □ Unknown	5 □	Other (specify)			
σ.	ires that signed b		Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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8	0 - 0	Ē				autopsy	ed? death?	opsy findings available ompletion of cause of
g	siclan: The certificate rector, pag	BeC	25. Was case referred to medical		26 Place of Dec	1 □ Yes 2 ath (Check only o e		2 No
>	nysic lis ce direc	일	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient	Other:	111	ce 6 Other (Spec	ify)
0	ding Phys h. After this funeral dir	Ę.	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury	28c. Injury at Work?	28d. Describe how		
0	endin sath. or: A he fu	atic	2 Accident investigation	,,	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	frect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office	28f. Location (Stre	eet and Number or Ru State)	ral Route Number,
	Hospital or Attending Physician: 44 hours atter death. Funeral Director: After this certificately filled in by the funeral director, t							
	a. (V a. (D)	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination are and manner stated.	e, death nd/or inv	occurred at the time, date and plac estigation, in my opinion, death occ	e, and due to the car urred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	296	d. Date signed (Month	, Day, Year)
1		-	Van MD		D54879		7/17/0	
	7		30. Name and address of person who completed cause of death (Item 23a)	(Type, P			Salish	ury.
			Greg M. Treuth, m.D. P.	R. r	nc-100 E Car	roll St.	MD. 2	1801
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Lan	di s			
	Registra	ar	JUL 2 3 2008 Leves IF,	September 1				

State of Maryland / Department of Health and Mental Hygien) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** July20 2008 9:45/P В. Plantz /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles 706 Pine Street La Plata If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Months 1⊠M 2□F August 12,1919 New York Director 075-07-7466 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "nature" any injury or other transcent. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☑ No La Plata MD Charles Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20646 706 Pine Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education 5+ Shop Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Plantz Olia Vanduzee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 706 Pine Street, La Plata, MD 20646 Miriam Plantz/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gar, 7/24/08 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee м00945 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗆 No 3 🗌 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2⊞ 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home Presidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification; To 1 Yes 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1-Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

i Director: Af

od in by the fur 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 1 4 Homicide within 24 hours a Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the h 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w 0 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - State Registrar			Cer	tificate of	Death		•	Reg. No	2008	3 23	340
	Physicia		1. Decedent's Name (First, Middle LTLA	e, Last) MAE	PAT	ΓERS	ON			2. Date of D		ay 2008 ^{ear}	3. Time of 5:55	Death A M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)		Ţ	4b. City, Town, o	or Location	of Death		40	c. County of Dea		
		Н		NURSING HOM	E		CLINT	ON				PRINCE O	GEROGE'S	5
Ì	Funeral Director		5. Social Security Number 248-36-2352	6. Sex 7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, D NOV 2	irth Day, Year 192	9. Bin C 20 SOU	rthplace (State of ountry) JTH CARC	
	land it		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside C	ity Limits
	the Marylan 28a-f show	ţōr	MD PRINCE	GEORGE"S	тЕМІ	ו עונ	HILLS						M⊠Yes	2 No
	r 28a	irec	10e. Street and Number	CLORGE 5	LLILI	ا نابا	10f. Zip Code				10g. C	itizen of What C	ountry?	
	th wit	a	2915 BRINKLEY	ROAD # 101			20748					USA		
	rdea	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. V	las Decedent of F Yes, specify Cub	Hispanic Or	rigin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whit		
	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, its Modical Evan free roughts and iting at	þ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	ried 1 □ Yes 2 □ XVo)		□Yes 2 X □No			, , , , , , ,	. 2		BLACK	
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2	filed Hygi other ent, I		17. Father's Name (First, Middle,	Last)		ابتلكر	<u> </u>	18. Moth	er's Name	(First, Middle				
<u></u>	Aental Aental rked o	To Be	ROBERT CORL	EY				C	LARA	FOST	ſΕR	•		
Mai	es 1 and 2 should b of Health and Ment I Item 27 is markec r other traumatic e		19a. Informant's Name/Relations ERNESTINE PAT				Address (Street							2074
ני ב	s 1 ar		20a. Method of Disposition		20b. Place o	of Dispos	ition (Name of atory or other pla	1	D	ate	20c. L	ocation - City or	Town, State	
2	Page nnt: II iny or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1		ZEMETERY		7/28/	2008	SUIT	ΓLAND, ΜΑ	RYLAND	
<u> </u>	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service	Licensee		22.	Name and Addre	ess of Facili	ity T	B IFN	KINS	FUNERA	I. HOME	
,	90 E 29		PF Wan 1	edernon.			474 LAND		ROAD	LANDOV	VER,	MARYLANI	20785	5
				complications that caused to only one cause on each line	he death. Do	not ente	r the mode of dyi	ng, such as	s cardiac c	r respiratory	arrest,		Approximat Interval Bet Onset and	ween
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5	eath certificate be executed attending physician and for use as the burial-transit	Med	IF FEMALE:					- 32					ĺ	
2	0 20	sician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	☐ Fetal deati		Ectopic pregnand	су			1	23d. Date of de Month	-	Year
;	at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death	5∟	Other (specify) _						,	
	g 99 3	/ Phys	Part II. Other significant condition	ons contributing to death but	not resulting i	n the un	derlying cause giv	ven in Part	l.	23e. Did	tobacco	use contribute t	to the cause of o	death?
3	w requires s been signi should be	d by								1 🗆	Yes 2	<u> </u>	Probably 4 ☐	Unknown
5	law rec as bee 2 shot	Completed								24a. Wa:	s an	24b. Were a	utopsy findings	available
	The la	E O			-					_ perf	opsy formed?	death?	utopsy findings completion of c	ause of
3	Physician: r this certifica ral director, p	Be C	25. Was case referred to medical examiner?					26. Plac	e of Death	1 □ Yes (Check only		0 1111111	s 2 <mark>∏</mark> No	
	hysic this call dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatien	t 2 🗆 ER/O	utpatien		4 (24 11	ursing Hor	ne 5∐Res	sidence	6 ☐ Other (Spe	ecify)	
	Ilng F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Injury (Month, Day,	Year) 28b.	Time of Injury	28c. Inju Wor		i	28d. Describe	how inju	ary occurred		
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	al or A s after I Direct	Certification:	4 ☐ Homicide determ	ined 28e. Place of Injurbuilding, etc.	(Specify)	ariii, Sire	et, lactory, office		l'	City or To	(Street a wn, Stai	and Number or Fi te)	iurai Houte Nurr	nber,
	Hospi 4 hou Funer tely fill	Medical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of	examination a	e, death	occurred at the t	ime, date a opinion, de	nd place, ath occurr	and due to th	e cause(e, date ar	s) and manner and place, and du	as stated. e to the cause(s	 s)
	ro the within 2 Fo the comple	Mec	29b. Signature and title of certifie	and manner state	eu.		29c. Licens	se number			29d. D	ate signed (Mon	th. Day. Year)	
	FSF6		Will	Worren_			D35					JLY 22,		
İ	01		30. Name and address of person	10	ath (Item 23a)	(Type F						,		0774
	3		WILLIAM TANNE	R M.D. 11701	LIVIN		N ROAD S	UITE	101	FORT.	WASH	INGTON,	MARYLAI	ND
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State of Maryland / Department of Health and Mental Hygieneo

			For State Registrar	State of Mai	-	ariment of H rtificate of L			eg. No.	3 S	25347
c	Physici	an	Decedent's Name (First, Middle, Last) Long C. Deve 1.0					Date of Deat Month		Year	3. Time of Death
	/Medic	al	James Dougla		.e 	4h City Town or	Location of Death	July 16	2008 4c. County of	of Dogth	3:00 P M
	Examin	er	4a. Facility Name (If not institution, give			Clinton			Prince		orga!c
	Funeral		Clinton Nursing 5. Social Security Number 6. Secur	x 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			place (State or Foreign atry)
ы	Director		577-74-0343	XM 2□F 55	Yrs.	Months Days	nours Will.	March 8	, 1953		hington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary fled a	tor	Maryland Prince G	eorge's	Clint	on					1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	itry?
	23a c	ral	9211 Stuart Lane			20735			United		
	er deg	Funeral		12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)		, White,	
36	irs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛱 Divorced	1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 🛣 No	Specify:		Specify:		frican erican
9	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show attc event, the Medical Examiner must <u>be notifled at</u>	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Bus		
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	kind of work done of DO NOT use retired	i)	9			
2	iled w Hygie ther th		9 years 17. Father's Name (First, Middle, Last)		<u> </u>	sician	18. Mother's Name	e (First, Middle, i	Self I	_	oyed
au	ld be lental l	To Be	Herbert Purdie					Bell Ea		-,	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Ty	rpe. Print)		ng Address (Street a					Code)
Baltimore, Maryland 21215-0036	and 2 ealth a n 27 is		Nea Purdie - Dau	ghter	1	Apperson					
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Dispersion of Computer 20 cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - 0	City or To	wn, State
Ħ Ħ	it. Partmen rtant: njury	19	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Harmony	Mem. Park 2. Name and Addres	July	<u>26, 200</u>	8_Lando	over,	, MD
Ba	permi Depar Impor any ir	J	21. Signature of Furneral Service Licens	18801	1114	001 Benni				-	
			23a. Part1 onter the disease, or complishock o heart failure. List only o	lications that caused t	he death. Do not en						Approximate Interval Between
	Physician		Immediate Cause Final disease or con thinn		munodefic	iency Vir	110				Onset and Death
1	/Medical		resulting in death)		consequence of):	Tency VII	43				
В	Examiner	Ļ.	Sequentially list conditions,	b							
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):						
Ć,	execunary and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	ificate be executed g physician and as the burial-transit	edical		d							
	± 00 €		IF FEMALE:								
Box	The law requires that the death cert ate has been signed by the attendin, bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1☐Live birth 2	PEtal death 3	Ectopic pregnancy	1		23d. Date Mor		ery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	ime or death 5	Other (specify)					
ν, σ	w requires that the deben signed by the should be detached	y Pr	Part II. Other significant conditions co		not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use contri	ibute to th	he cause of death?
ğ	equire en sig ould b	Completed by	Amyotrophic Sclere					1 □ Y	es 2√2 No	3□ Prob	oably 4 ☐ Unknown
မင္ပင	law ru as be	plet						24a. Was a	sv p	Vere auto	opsy findings available mpletion of cause of
<u>=</u>	: The cate h	Con						perfor 1□ Yes		leath? Yes	2 No
<u> </u>	siclan certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:		nt 30 DOA Oth	26. Place of Deat				
ō	Attending Physician: r death. ector: After this certification by the funeral director.): To	27. Manner of Death	28a. Date of Injury	/ 28b. Time o	III 3 DOA	4 K I Nursing Ho		ence 6 ☐Othe ow injury occurre		<u>y)</u>
Ö	ath. rr: Affe	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		K? Yes 2 □ No				
Division or Vital Records,	r Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
	oital o urs aff eral D		On Cartifica 1 On this Bloom			41	data and alara				
	Hospital 24 hours a Funeral l etely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination and/or i	nvestigation, in my c	me, date and place, opinion, death occur	red at the time, o	date and place, a	nner as s and due t	tated. o the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	~		29c. Licens	e number	2	29d. Date signed	(Month,	Day, Year)
	2		Wille () Jan	reig	D3520	6		July 23	3, 20	008
	BI		30. Name and address of person who c				- 1				
			William T. Tanne			gston Rd.	Ft. Wash	ington,	DC		
	Sta Registi		31. Date filed (Month, Day, Year)	اللم معالي	r's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Projection of Cooling Survival (Associated Survival Cooling Survival Cooli	open Kassen		1- For State Registrar	ate of Maryland /		tificate of		a mente		Reg. No.	UU	3 2534
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The street of Number 100 and	n y				10c. City,	Town or Location	n				1	0d. Inside City Limits
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1 Martin Studies 1 Martin Stu	Jaryla 1 at on	ectc	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Countr	y?
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	S	tate	31. Date filed (Month, Day Year)	57			- Da Dot, Dai			<u> </u>		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** July 29, 12:30P M Jack Douglas Sanbower /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Smithsburg 23468 Whitetail Rd. if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1√2 M 2 □ F 47 214-84-3025 Sept. 14,1960 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location show 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Smithsburg Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 23468 Whitetail Road U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Band / Music Musician s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John G. Sanbower Geraldine M. Stephy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is i 23468 Whitetail Rd. Smithsburg, Maryland 21783 John G. Sanbower 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ringgold Cemetery Ringgold, Maryland 4 Donation 5 Dother (Specify) 2008 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 avis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ments ~ **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown 23e. Did tobacço use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2□No 1 □ Yes 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: After 1 Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 11110 146 ha rvecle 1. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 6 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per inf g885 11-14-08 vt. State of Maryland / Department of Health and Mental Hygien 2 0 8

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		For State Registrer 1. Decedent's Name (First, Middle, L	ast)		ertificate of L	Jean	2. Date of Do		ay Year	3. Time of Death
Physicia		CAROLYN	JEAN SMIT	ГН			July	30	2008	2:30 A
/Medic	_	la. Facility Name (If not institution, g	ive street and number,		4b. City, Town, or	Location of Death		4	c. County of Deat	h
LAGITHE		1916 Castleton Ro	oad		Darlingt	ton			Harford	
Funeral			Sex 7. Ag	ge (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	av. Year	9. Birt	hplace (State or Fore untry)
Director		220-40-9923	1□M 2XF	54 Yrs.			11/14/	194	3 <u>Ma</u>	ryland
*	-	Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Lir
f sho	ō	MD Harford	F	Darlingt	on					1 ☐ Yes 2 🔀
28a	Je -	10e. Street and Number			10f. Zip Code		-	10g. C	itizen of What Co	untry?
38 01	Funeral Director	1916 Castleton I	Road		21034				USA	
ms 2	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Bfack, Whit	nican Indian, e, etc.
nt of Health and Mentat Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. It a Madical Examiner must be notified at	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced		₹ /o	1 ☐ Yes 2XXVo	Specify:				hite
"natura	Completed	15. Decedent's (Specify only highest of		16a. De (G	cedent's Usual Occup ive kind of work done of a. DO NOT use retired	ation during most of work	ring	16b.	Kind of Business	Industry
than	ошо	Elementary/Secondary (0-12)	College (1-4or	5+)	emaker	-,		0	wn Home	
Hygi other ent, I	ပိ	17. Father's Name (First, Middle, La	st)	11011		18. Mother's Nam	e (First, Middl	e, Maide	en Sumame)	_
fental rked i	To Be	Elijah D. Petty				Lula Ma				
s mai		19a. Informant's Name/Relationship	_	19b. M	ailing Addy 30 Street	and Number or Ru	al Route Num	ber, City	or Town, State,	Zip Code)
alth an 27 L		William H. Smit	n/Husband		Box 37 For			2105		Taura Chat:
Department of Health a Important: If item 27 Is any injury or other tra		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			sposition (Name of crematory or other plac con Cemeter		Date 2008	1	Location - City or rlington	
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35		23a. ant. Life the disease, or co shock, or heart failure. List or	omplications that cause by one cause on each	ed the death Do not line.	enter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Betwee Onset and Dea
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Medical		resulting in death)	Due to (or a	s a consequence of):	ung Car					4
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attendin I for use	ciar	in the past 12 months?	4□Pregnant	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			Month	Day Yea
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	o Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	atient 3 DOA Ot	her: 4 Nursing H	1		6 ☐Other (Sp	ecify)
s certifica director, p		27. Manny of Death	28a. Date of Ir (Month, L		ne of 28c. Inju			e how in	njury occurred	
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Please Type or Print in Black Indelible Ink/ Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ,^{Day}2008 July 20, **Physician** 6:59 Shockley Lois Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Salisbury Wicomico 2808 Merritt Mill Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min 1 □ M 2 🕱 F Months Hours 213-24-1754 81 Director 9/20/1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinor must be notified at 1 □Yes 2¶TNo Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 2808 Merritt Mill Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify white 3 ★Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Perdue Farms secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Hester Parker Willis H. Bratten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5521 St. Andrews Dr., Salisbury, MD 21801 Donna M. Hitch/daughter permit. Pages 1 and Department of Healtl Important; If item 27 any injury or other tonce. other 20b. Place of Disposition (Name of cemetery, crematory or other place WICOMICO MEMORIAL 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/23/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee CFSP Dompson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) ongestic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels consequi-The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical attending IF FEMALE: signed by the attendin be detached for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) the 9 Unknown o 9 Unknown يَم 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiful 23/2008 30. Name and address of pe to completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:00A M 9 2008 MARY MARTHA THOMAS JULY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 👿 F Months Days Hours Min. 215-38-4511 FEB 1, 1940 MARYLAND 68 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No OXON HILL PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 UNITED STATES 2117 ALICE AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE MANAGER 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERNICE GREENE BROWN JOSEPH LEROY BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA THOMAS/DAUGHTER 2712 OVERDALE PLACE, DISTRICT HEIGHTS, MD 20747 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State SACRED HEART CEMETERY 7/29/2008 | LAPLATA, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicensee RNTON FUNERAL HOME, P.A. 9 LIVINGSTON ROAD, INDIAN HEAD, MD LYDIA C. THORNTON JOHNSON MUSTS 20640 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardia ARDIONY OPATH Immediate Cause (Final disease or condition resulting in death) Due to (or as a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? alma 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ⊠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If Itel
any injury or ott

Physician

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Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show The Medical Examinar must be notified at

traumatic event, if Health and Mental Hy

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Baltimore, Maryland 2121

HOMAS

Funeral Director

Completed by

Be

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MD

Examiner sician and burial-trans attending physician Physician/Medical for use as the signed by the a Completed by page 2 should has been certificate Be Certification: To this After thi

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Hornicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABILAH H.O REXFURD

20770 7500 HANDUER PARKINAY SUITE 101A GREENBERT

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008 32. Sgistrar's Signature

ours after death. leral Director: A filled in by the fu

completely

29a. Certifier

To the Hospital o within 24 hours af To the Funeral Di

S. Social Security Number State of Security	e 0000 05051
Physician Month	
4a. Facility Name (if not institution, give street and number) 4 103 Hamilton Street Funeral Director 5 59-56-9003 1	ay Year 2008 3. Time of Death 2:20 P M
S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ft. Under 1 Year Ft. Under 24 Hrs. 0 0 0 0 0 0 0 0 0	
State The part of the part	Prince George's
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 2 No 9 Unknown 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of del Month 1 yes 2 2 No 9 Unknown 2 Unknown	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Seisure Disorder Seisure Disorder Diabetes Mellitus 24a. Was an autopsy performed? Imperior of death? Diabetes Mellitus 25. Was case referred to medical examiner? 12	
Seisure Disorder Seisure Disorder 24a. Was an autopsy performed? 24b. Were autoprofused death? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 27b. Was case referred to medical examiner of the case of Death (Check only one) 27b. Was case referred to medical examiner of Double examiner of Double examiner of Double examiner of Month, Day Year) 27b. Was case referred to medical examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of Double examiner of	use contribute to the cause of death?
Selsure Disorder 24a. Was an autopsy performed? 1 Yes 2 Mo 1	2 No 3 Probably 4 MUnknown
Diabetes Mellitus	24b. Were autopsy findings available prior to completion of cause of death?
examiner? 1	
27. Manner of Death 1	6 □Other (Specify)
2 Accident 3 Suicide 4 Homicide 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 Be. Place of injury - At home, farm, street, factory, office 2 City or Town, State) 2 9a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.	
The state of the s	
29a. Certifier (Check only one) 29a. C	and Number or Rural Route Number, ite)
Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durand manner stated.	(s) and manner as stated.
900 Linear water	nd place, and due to the cause(s)
	Date signed (Month, Day, Year)
3 Albert Rolle M.D. D0007967 7/22/08	1122100
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert E. Rolle, MD 600 River Bend Rd, Ft. Washington, MD 20744	.4
State 31. Date filed/Month. Pay. Year) 32. Registrar's Signature	7

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20, July 2008 6:23 P. M Celestine Watson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Months 66 11/24/1941 Director 577-54-3514 Halifax, N.C. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 45th Place N.E. 20019 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White_etc.
African—

pecify: American permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event. The Marinal Exement 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Administrative Officer Department of Transportation Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Department of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Watson, Sr. Novella Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keonna M. Watson/Daughter 910 45th Pl., N.E., Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. 07/28/08 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses au, 104 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of). Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner End Stage Kidney Disease attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Day Year 4<u>□</u>Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □ No 1∐ Yes 1 Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D41405 July 23,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman Allen, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Yea 2008

DHMH 17 Rev 1/2001

State Registrar

		For State Registrar		State o	of Maryla	nd / Dep	artment o			and M	ental Hy	_				
		Registrar 1. Decedent's Name (First, Mid	idle, Last)			Ce	rinicate	OI D	eain		2. Date of De	Reg. No.	200	8_	3. Time of	356
Physicia /Medic		Kenneth Eugene		Ч							Month 7	Day 20	200		6:18	2 am
Examin		4a. Facility Name (If not institut			mber)		4b. City, To	wn, or L	ocation o	f Death			County of De		0.10	aiii
	96	Atlantic Gener					Berl		16 11 1				Horces			
Funeral Director		5. Social Security Number 219-34-1364	6. Sex	M 2□ F	7. Age (In yr	s. last birthday Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 7/16)	1937	9. E	irthpla Countr	ce (State o y) MD	r Foreign
p ,		Usual Residence of Decedent			100.6	Sib. Town and								1.0		
faryla shov	io l	MD Howa			100. 0	Columb								100	d. Inside Cit 1 ☐ Yes	-
the N 28a-f notifie	rect	10e. Street and Number	aru			Columb	10f. Zip C	ode	···			10a. Citiz	en of What	Countr		
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ems Ser mu	Funeral Director	11. Marital Status	1	2. Was Dec	edent Ever in orces?	U.S. 13.	Was Deceder If Yes, specify	nt of His	panic Orig	gin? (Spe	cify Yes or No)- 1	4. Race - Ar Black, W			
s afte	by Fu	1 ☐ Never Married 2 【 M 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Gi Year or D	2 X No ive		1 ☐ Yes 25		Specify:		, , , , ,		Specific			
2 hour atural cal Ex		15. Deced	lent's Educ	ation		16a. Dece	edent's Usual (Occupat	ion			16b. Kir	nd of Busines	/hit ss/Indu		
thin 72 e. an "na Medic	Completed	(Specify only hig Elementary/Secondary (0-12		completed) College (life.	NOT use	retired)	iring mosi	of workii	ng				·	
ed wil	Con	12				Mai	ntenace					1	me Rep	air	`	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Midd Kirby Wood	le, Last)								<i>(First, Middle</i> eters	, Maiden :	Surname)			
should and Me mark	은	19a. Informant's Name/Relation	onship (Typ	e. Print)		19b. Mail	ing Address (S	Street ar				er, City or	Town, State	, Zip C	code)	
and 2		Barbara Plinta	a Woo	d / wi	ife) Senec									
ges 1 t of He if iten or oth		20a. Method of Disposition 1 ☐ Burial 2 X Crematio	n 3 □R	emoval from	State 20b	. Place of Disp cemetery, cre	osition (Name ematory or othe	of er place,	,	D	ate	20c. Loc	cation - City	or Tow	n, State	
t. Pag rtmen rtant: rjury		4 □ Donation 5 □ Other	(Specify)			pe Hen				·	/2008		nkford			
permit Depar Impor any ir		21. Signature of Fune al Servi	14	Nose		2	2. Name and				Burbage Berlin,			lome	:	
200		23a. Par . Enter l' e dise . e, shock, or he rt failure. L	4		caused the de	ath. Do not er							21011		Approximat	e
Physician		Immediate Cause (Final disease or condition	list only on	e choeyon e	(MC	Cer	-1	1					, A	nterval Bet Onset and I	ween Death
/Medical Examiner		resulting in death)	a	Due to	(or as a cons	7000		1	n	1)			1,	LULVI	<u></u>
Lxammer	_	Sequentially list conditions if any, leading to immediate	ь	-C	One (or as a cons	nam	a	th	cro	20	(CAP)	_		C	Par	<u> </u>
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<	6		equerice di).	Atta	Y 1 <	ہا ہے	PCNC	212			1	100 00	2
exec an and rial-tra		resulting in death) Last	c	Due to	(or as a cons	equence of):	201 001	<u> </u>	,	<u> </u>				1	1	
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atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live	birth 2 ☐ Fe nant at time o	etal death 3	☐Ectopic preg☐ Other (spec					2	3d. Date of o Month		_	Year
that the de ned by the a detached i	hysi	1 □ Yes 2 □ No 9 □ Unknown		9□Unkr												
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	by P	Part II. Other significant cond	litions con	tributing to d	feath but not re	esulting in the I	anderlying cau	se giver	n in Part I.		23e. Did	tobacco u	se contribute	to the	cause of d	leath?
requir een si nould I	ted										10	Yes 2[]No 3∏	Proba	oly 4 🔼	Jnknown
ne law has b je 2 st	Completed										24a. Was	psy	prior	o com	sy findings pletion of c	available ause of
i cian: The certificate ha		25. Was case referred to medi	ion!								1□ Yes	ormed? 2X No	death 1 🗆 Y	es 2	!□ No	
iysician: iis certific director,	o Be	examiner? 1 ☐ Yes 2 ☒ No	_	ospital:	Inpatient 2		nt 3 DOA	Othor			<i>(Check only</i> ne 5 ☐ Res		: DOthor (6	naniful		
ding Phy h. After thi funeral (L:u	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	dina	28a. Date		28b. Time		Injury . Work?	at		28d. Describe			pecity)		
tendir eath. tor: A the fu	catic	2 ☐ Accident inve	stigation Id not be				M	1 □ Y	es 2 🗆 I	No						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to	Certification:		ermined		e of injury - At ling, etc. <i>(Sp</i> e	home, farm, s cify)	treet, factory, o	office		2	28f. Location (City or To	Street and wn, State		Rural	Route Num	nber,
spital		29a. Certifier 1 💢 Certif	ying Phys	iclan: To the	e best of my k	nowledge, dea	th occurred at	the time	e, date an	d place, a	and due to the	cause(s)	and manner	as sta	ted.	
he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medic	al Examir	ier: On the t	pasis of exami ner stated.	ination and/or i	nvestigation, ir	n my opi	inion, dea	th occurr	ed at the time	, date and	place, and	due to	the cause(s	s)
To t To t	Σ	29b. Signature and title of cert	ifier	V. (-		29c. L	icense	number			29d. Date	e signed (Mo	onth, D	ay, Year)	
		F MYSIII	rex	Lang	WW	_		5588				الد	14 2	المراك		
		30. Name and address of pers Melvin Kordon				, , , , ,		llic	ott	City	MD 2	10/12				
Sta	ite	31. Date filed (Month, Day, Ye	ar)	32.	Registrar's Sig	nature	.u. j L	1110	066	отсу	, I'IU L.	1042				
Registr	ar	MISO	000	onno	1	20	AND AR	~								

NK UNK	State of M 1-For State Registrar	laryland / Department of <i>Certificate of</i>		Reg. No.	2008 2535
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last)	Rea Yglecias		2. Date of Death Month Day July 20, 2008	3. Time of Death Year 1030 hrs
enical Examiner	4a. Facility Name (if not institution, give stree		b. City, Town, or Location of Deat	h . 4c. Co	ounty of Death
Supposed	Patapsco Park Bloedes Dam 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Elkridge If Under 1 Year If Under 24Hr		ward //////) 9. Birthplace (State or
Funeral Director	245-95-0862		Months Days Hours Mi		Foreida Ovico
апу	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on		10d. Inside City Limits
ž "	MD Montgomer	y Silver	Spring		1 Yes 2 XNo
with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street and Number 215 University F	Blvd.East	10f. Zip Code 20901		n of What Country? EXICO
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	1 Never Married 2 Married 1	Armed Forces? If Y	s Decedent of Hispanic Origin? (3 es, specify Cuban, Mexican, Puer Mexic Yes 2 No specify:	to Rican, etc.) Can	Race - American Indian, Black, White, etc. White
ours after a natural" d by	3 Widowed 4 Divorced or Divorc	hest grade completed) 16a. Deceden	t's Usual Occupation (Give kind o	f work done 16b. Kin	d of Business/Industry
5-0036 teed within 72 hour lygiene. the Medical Exar Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	porer		onstruction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Jose Rea Garcia			ne (First, Middle, Maiden St lupe Igles	· ·
7 5 6 6 5 O	19a. Informant's Name/Relationship (Type, I Bernardo Rea Igle	DICCITCI	Address (Street and Number of Fairport Ro		or Town, State, Zi2270565 North Carolina
a a all a	20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery,	Date 20c. Lo	cation - City or Town, State
Page Page sent c	1 XBurial 2 Cremation 3 XR 4 Donetion 5 Other specify:	Panteon	Municipal 8/	2/2008 _{Mia}	catlan,Mexico
Balti permit. Departi Importe injury o	21. Sign to re of Funeral Solvice License	一	TTTTPOODS. KTWAL 241 Columbia	DI FUNERAL Blvd.Silve	SERVICE,P.A. r Spring,Md2091
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760, cate be e physicial he burial	IF FEMALE: 25	3c. If yes, outcome of pregnancy		23d.	Date of delivery
Box 6876 e death certificate the attending phy ed for use as the luxeician/M	23b. Was decedent pregnant in the past 12 months?	The second of the second second	etal death 3 Ectopic pres ther (Specify)	gnancy	Month Day Year
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F Vital Physicians This certi al director	examiner? 1 Yes 2 No	1 Inpatient 2 Ervodipatien			nce 6 Other: Scene
on of \ anding Phy arth. r: After the funeral the		28a. Date of Injury Jul (Month, Day Year) Jul 20, 2008 28b. Time of 0830 hrs	Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injur Subject drowned	ry occurred
Division of Vital Records, P.O. spital or Attending Physician: The law requires that it near steer death. The service of the property of the filled in by the funeral director, page 2 should be detaconting in by the funeral director, page 2 should be detaconting in by the funeral director, page 2 should be detaconting in by the funeral director, page 2 should be detaconting in by the funeral director, page 2 should be detaconting in by the funeral director, page 2 should be detaconting in by the funeral director of the funeral di	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str. (Specify) River	eet, factory, office building, etc.	or Town, State)	nd Number or Rural Route Number, City des Dam, Elkridge, MD
hou hou		To the best of my knowledge, death occurrence the basis of examination and/or investig	urred at the time, date and place, ation, in my opinion, death occurre	and due to the cause(s) and ed at the time, date and place	d manner as stated. be, and due to the cause(s)
2	29b. Signature and title of certifier	d manner stated.	29c. License number	29d. E	Date signed (Month, Day, Year)
V	V 1100	504D	O.C.M.E.	July	21, 2008
	30. Name and address of person who common Tasha Greenberg MD. Ass		1 Penn Street, Baltimore,	MD 21201	
Stat	e 31. Date filed (Month, Day, Year)	32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Philip Wayne Alder 9:00 A M 6 2008 Aua /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Mount Airy 5690 Ridge Rd. Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 1074471940 Days Hours 1XXM 2□ F 67 213-40-1895 VA Director Usual Residence of Decedent es 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene.

item 27 is marked other than "natural", or items 220 - - - - - other traumatic auch. 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Carroll Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5690 Ridge Rd. 21771 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ∐Yes 2√DtNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Henkles & McCoy Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Mae Parks Calvin James Alder ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5690 Ridge Rd., Mt. Airy, MD 21771 Mitzie Amanda Alder/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Ridge Cemetery 8/9/2008 Woodbine, MD 21. Signature of Funeral Service Licenses 2Burrierd Gueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Lause (Final diseaser conditions) Approximate Interval Between Onset and Death CHRONIC OBSTRUCTURE PULMONBRY YEARS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, SQUAMOUS CELL CANCER RIGHT EAR 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 → No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CARDIOMYOFATA page 2 ACUTE RENAL certificate this certificaral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After thi 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 1/Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated

3 Registrar's Signature

29c. License number 031761

SOI W. SEVENTH STI

29d. Date signed (Month, Day, Year) 8/7/2008

FREDERICK MD 21701

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 10:48PM oria 2008 am5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
7.25.1942 **Funeral** Hours 66 212-40-4954 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Pres 2 □ No WD Baltimore 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 21205 Funeral , or items Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 Ne Specify Š If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natura!", Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Health e 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other trat once. hussel Adams ame of Date 20c. Location - City or Town, tate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Darial 2 Cremation 3 Removal from State 8.8.2008 Baltimore, Mi 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Vaughn C. Greene Funeral Service

4905 York Pod Baltimore MD 21212

23a. Part 1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Immediate Cause (Final **Physician** disease or condition resulting in death) stive leart /Medical Due to (or as a consequence of): Examiner per ten Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day 5 Other (specify) d by the al Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown been sign should b 1 TYes 2 No 3 Probabiy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has builtiector, page 2 s autopsy performed? Yes 22 No 1 🗌 Yes 1 Tes 2 🗌 No in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗆 Inpatient 2X ER/Outpatient 3 □ DOA ၉ 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. after death 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours aft

To the Funeral Dil

completely filled in Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29d. Date signed (Month), Day, Year) 30. Name and address of person who comp 600 North Wolfe St, Baltimore, MD, 21287

State

Registrar

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760, Spanial or Attending Physician: The law requires that the death certificate be executed be recorded by the safer death.

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 5, 2008 Year ANNF BELLINGER **ARCHER** 11:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Franklin Square Hospital Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 🗌 M Rhode Island Director 256-16-0289 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □ Yes 2 📆 🏋 0 Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 21234 8800 Walther Blvd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĀM No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: White Š XX Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Candler Dobbs Frederick Lyle Bellinger ပ္ 19a. Informant's Name/Relationship (Type. Print)
Margaret Archer-Batten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Thetford Road Baltimore, Maryland 21286 Dtr 20a Method of Disposition

XX Burial 2 □Cremation 3 □Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Union Chapel Meth Ch Cem Aug 9, 2008 Fallston, Maryland ☐Donation 5 ☐ Other (Specify) Ignature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Hm Inc 6500 York Road Baltimore, Maryland 21212 nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmanary Fibrosis- End Stage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any Leon Conditions, if any Leon Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably X \ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∐ Yes **A** \ \ \ \ \ No certificate Il or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: XX Inpatient Other: 4 Nursing Horne 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral D 🗡 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) mo D53115 August 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff Underman MD 8800 Walther Blvd Baltimore, Maryland 21234 31. Date filed (Month, Day, Year) AUG 0 7 State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

25362

_		Certificate of Death	Reg. No.
	Physicia		2. Dete of Deeth Month Dey Year 3. Time of Death
	/Medica	Christopher Thaterson	8 4 08 6:15am
	Examine		4c. County of Deeth
	Funeral	5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth 9. Birthplace (State or Foreign
	Director	249-30-4681 1XM 20 F 83 Yrs. Months Days Hours Min.	5.12.25 South Cardina
	pue *	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
8	r 28e-f ehow		1 Yes 2 □ No
à	r 28e-f	10e. Street end Number	10g. Citizen of What Country?
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1	Herns her m	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.) 14. Race - American Indian, Black, White, etc.
phe,	or the	Yes, Give 1 ☐ Yes 20 No Specify:	Specify: Ray
hristophe 21215-0020	within 72 hours after death with the Maryland ene. than "naturel", or teems 23e or 28e-f ehow he Medical Examiner must be notified at	3 Widowed 4 Divorced Yeer or Dates: 15. Decedent's Education 16e. Decedent's Usual Occupation	16b. Kind of Business/Industry
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and	ould be fill Mental H arked ott	17. Father's Name (First, Middle Last)	(First, Middle, Maiden Surname)
Maryland	2 should be filed end Mental Hygi le marked other aumatic event, I	19a. Informant's lame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	Route Number City of Town State Zin Code)
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altimore,	Peges 1 end 2 nent of Health e ant: if Item 27 le ury or other tra	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
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Balt	permit. Peges Depertment of Important: if it any Injury or pace.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Coseah L. Kuss Fu	icil na
	40 = 6 0	(Clyssly Stay 2222 W. North	Avenue Bats MD 21216
		23a. Part . Enter my disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between Onset and Death
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ā	rs efte	building, etc. (Specify)	City or Town, State)
	o the Hospital or Attending Physi- ithin 24 hours efter death. 3 the Funeral Director: After this completely filled in by the funeral director.	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
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	4 5	30. Name and eddress of person who completed cause of deeth (Item 23e) (Type Print)	,
	-	301 St. Paul Raw # 601 (Influe MD 21202,	
	State Registra	7110 0 P 0000 Wh	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Brown 3eurgianna /Medical AUGUST 2008 11:03 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** itosp. TAL Union memorial BAITIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F 213-26-8626 **Director** 16 ΜD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Baltimore MI, an dalls 1 ☐ Yes 2 No Director TOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23a or the Modical Examiner must be r aur Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23; any Injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTING HOUSE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ +aze1 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILLRA ilford SOM Balto .mo 1 Car Do Mariano 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sent re f Funeral Service Licenses 22. Name and Address of Facility LIBERTY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UROSEPSIS DAYS /Medical Due to (or as a consequence of): Examiner 11 DAYS FUNGAL SEPTICE MIA Sequentially list conditions, the product cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Physician: The law requires that the death certificate be executed POSTERIOR FOURH MENINGIOMA PARTIAL EXCISION 1 MONTH Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical DIABETES 20 YEAR MELLITUS IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KULKARNI, MD AT 2438946 AUGUST 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

RANI

31. Date filed (Month, Day, Year)

ME MORIAL HOSPITAL, BALTIMORE,

UNION

MD

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 Physici /Media Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Pureral Directors: After this certificate has been signed by the attending physician and commissive filled in by the funcared intention can 2 should be detached for use as the burish-transit Division of Vital Records, P.O. Box 68760,

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of Health and Mental Hygiene. Of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at		Meghan M		ynn /Mo		7 v	<u>'illag</u>	e 1	/a1e	Ct.	Reis	ter	stow	n,	MD 2	1136
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			1 - For State Registrar		State of Ma	aryland				lealth and Death	Men	, ,	_	2008	25	5365
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:	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 9022 Hedge	erow Way				10f. Zi	Code 212	36		10	g. Citize	en of What Cou US	-	
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ני , בי	signed by the a	þ	Part II. Other significant of	conditions contr	ibuting to death bu	ıt not resultir	ng in the un	derlying o	ause give	en in Part I.		23e. Did tob		contribute to		of death?
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Ļ	Vithi Comp	ž	29b. Signature and title of	certifier	1-1-1	1)		29	c. License	e number		29	d. Date	signed (Month	Day, Yea	r)
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** \mathbf{P}^{M} 5, 2008 6:16 Aug. William Abraham Beery, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Ye Oct, 19, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1916 **Funeral** Days 1**X** M 2□ F Maryland Yrs 91 212-05-4947 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Timonium MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2525 Pot Spring Road Unit L530 21093 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food/Entertainment Restaurant owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugenia Korn William Abraham Beery, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Pot Spring Road L530 Timonium, MD 21093 permit. Pages 1 a.
Department of Heat.
Important: If item 27 any Injury or other Alpha Baxter Beery/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Pulaney Valley

Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Aug. 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Lemmon Funeral Home of Dulaney VAlley 10 W. Padonia Road Timonium, MD 210 21. Signature of Funeral Service Licenses Michael J. Flagle 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death -31/10 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of) Examiner 110 Sequentially list conditions, if any limiting cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2X No 1 ☐Yes 2 ☐No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Maryland

Baltimore,

P.O. Box 68760

Vital Records,

of

State Registrar 29b. Signature as

DR. EDDIE NAKHUDA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

6-08

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, perMp. 882 8/7/08/TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AUGUST 2008 2:00 P EDNA MAY BARRINGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2809 Emmorton Road Harford Abingdon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 19, 1923 Sirthplace (State or Foreign Country)
North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 X F 214-16-6208 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Director Maryland Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21009 2809 Emmorton Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2₩ No 1 Never Married Married 1 ∐ Yes 2√2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Caroline Reed Andrew Mack Cochran ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other traionce. 2809 Emmorton Road, Abingdon, Maryland 21009 Charles Barringer / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Buri≰l 2 Cremation 3.☐Remova Bel Air Memorial Grdn 8-6-08 Bel Air, Maryland 4 □D4nation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signa e of Funeral 317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 116/1 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examiner or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the buriat-1 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Jes, outcome pripregnancy 1 □Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 3 ☐Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 Yes 2 No မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Average within 24 hours after death.

To the Funeral Director: Aft 1 TYes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and itle of

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

17/6 HARFORD Rd Suite 105 FALSTONM9204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TO

Year)

31. Date filed (Month, Day,

C. VALARAO, T.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5, 9:15 PM Anna J. Clemens Aug. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holly Hill Nursing Home Towson der 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🗓 F 84rs 216-20-8248 July 15, 1924 Director Maryland Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2X No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō filed within 72 hours after death with 531 Stevenson Lane "natural", or items 23a 21286 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wii Department of Health and Mental Hygien Important: If item 27 is marked other thu any Injury or other traumatic event. In 12 N/A Transportation Claims Clerk Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Michael J. Lhotsky J. Sluka Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 W. Padonia Road Cockeysville, MD 21030 Mildred V. Vogel/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9, Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem. 4 Donation 5 Other (Specify) 2008 Baltimore, MD 21. Signature of Europal S Lemmon Funeral Home of Dulaney Valley, Inc. Flagle 10 W. Padonia Road Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician 20 4005 disease or condition resulting in death) Dromary /Medical Due to (or as a consequence (4): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 ☐ Yes 2 No 2 🗆 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Trursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

2008

P.O. I

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25370 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Richard Roscoe Cook 2008 10:40 P August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Be1 If Under 1 Year Air If Under Hours Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Months 1**⊠**M 2□ F Days 235-18-9351 92 June 21, 1916 West Virginia

Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exercitors in ust be notified at once.

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be exer within 24 hours after death To the Funeral Director:

State

Registrar

NNenna

31. Date filed (Month, Day, Year)

	10a. State	10b. County		10a City Town	011000	tion					40d Incide City Limite
_	Toa. State	Tob. County		10c. City, Town	OI LOCA	lion					10d. Inside City Limits
Funeral Director	Maryland	Harfo	ord	Bel A	lir						1 ∑Yes 2 □ No
ire	10e. Street and Nur	nber				10f. Zip Code			10g. C	Citizen of What Co	ountry?
al [403 Linw	ood Aveni	ie.			210	14			USA	
Jer	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Wa			in? (Specify Yes or I	No-	14. Race - Am	erican Indian.
Ξ		ied 2□ Married	Armed Forces? 1 XYes 2 ☐ I	No	lf Y	es, specify Cu	ban, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)		Black, Whit	
þ	3 XWidowed		If Yes, Give Year or Dates:		1 🗆	Yes 2 XN	Specify:			Specify:	1-21
ed		15. Decedent's Ed	!	169	Deceder	nt's Usual Occi	ination		16h	Kind of Business	hite //ndustry
Set		cify only highest gra	ide completed)		(Give kir	nd of work done NOT use retir	during most	of working	100.	Killa of Business	/industry
Completed by	Elementary/Second 12	ndary (0-12)	College (1-4or 5	1+) [,		,	T.C. Corr	
Ö	17. Father's Name ((Eiret Middle Last		Edit	TIOI	ilentar		Operator 's Name (First, Midd		J.S. Gov	erment
Be								,		,	
မ		Goff Cool					Viaa	Emily Bel	Lcnei	<u> </u>	
	19a. Informant's Na	ame/Relationship (Type. Print)	19b.	Mailing.	Address (Stree	t and Number	or Rural Route Nun	nber, City	or Town, State,	Zip Code)
	Linda Co	ok Kaiss	/ Daughte	r 4	103 I	inwood	Ave.,	Bel Air,	MD 2	21014	
	20a. Method of Disp	position	_	20b. Place of		ion (Name of tory or other pl		Date		Location - City or	Town, State
	1 XI Berrial 2 L	☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	/		morial	- 1	0_0_00	D _C	-1 7 in 1	Maryland
	21 Signature of Su			TEL AL	/ 22 N	Jame and Add	ess of Facility	8-8-08		ET ATT, I	Martana
		<i>[[[]</i>]]	-/_ /////	19011	\perp _Mc	:Comas :	Funera]	L Home, P.	Α.		
7 11	-11/1/	WSX -	pli stions that caused	1/1/1	1	317 Cok	esbury	Rd., Abir	ngdor	n, MD 21	
	shock, or hea	rt miture. List mly	one cause on each lir	ne.	ot enter	me mode of dy	ing, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
1	Immediate Cause (Fin disease or condition resulting in death) a. Acute Cerebrovascular accident										Onset and Death
4	Due to (or as a consequence of):										reays
	Sequentially list conditions b. Atroal Fibrallation										
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										12003
Ē	Cause (Disease or that initiated events	injury									
Exa	resulting in death) L	_ast	Due to (or as	a consequence o	of):						
a			na -								
Completed by Physician/Medical Examiner			u		-						
Š	IF FEMALE:		23c. If yes, outcome	of pregnancy				_			
ial	23b. Was decedent in the past 12		1 Live birth	2 Fetal death		ctopic pregnar				23d. Date of de Month	elivery Day Year
/sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNo	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 🗆 С	other (specify)			-		Duy Tou
F P											
þ	A a . La		ontributing to death b	_	the unde	erlying cause g	iven in Part I.	23e. Di	a tobacco	o use contribute t	o the cause of death?
eq	- ACUTE	Rona	1 Failu	pe				10	Yes	2 □ No 3 □ P	robably 4 Unknown
Set	Dehu	tration)					24a. Wa	as an	24b. Were a	utopsy findings available
Ē	7		/						topsy rformed?	death?	utopsy findings available completion of cause of
ŏ	25 Was appa refer	rad to modical						1 □ Yes	2 2	No 1 □Ye	s 2□No
ă	examiner?	,	Hospital:				26. Place of	of Death (Check only	y one)		
Ë	1 Yes 2		1 A Inpatie	ent 2 ER/Out		3 LI DOA	4 🗆 Nur	sing Home 5 ☐ Re			ecify)
0	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ry 28b. T <i>y, Year)</i> Ir	ime of njury	28c. Inj			e how inj	ury occurred	
cat	2 Accident	investigation 6 Could not be				M 1[]Yes 2□N	0			
₿	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju- building, etc	ury - At home, far	m, street	, factory, office		28f. Location	(Street a	and Number or R	ural Route Number,
Se								0.17 0.1	,		
<u>a</u>	29a. Certifier	Certifying Ph	ysician: To the best	of my knowledge	, death o	ccurred at the	time, date and	place, and due to the	he cause	(s) and manner a	as stated.
Medical Certification: To	(Check only one)	∠	niner: On the basis o and manner sta	f examination and	d/or inve	stigation, in my	opinion, deatl	n occurred at the tim	e, date a	ind place, and du	e to the cause(s)
Me	29b. Signature and	title of certifier	0 1	1 lips	Pirdi	29c. Licer	se number	-	29d. D	Date signed (Mon	th, Day, Year)
	> Ucho	ndu lu	sternel M	rectione			10613	260	n	and D	5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

08-0588	31
Karen A	Crocetti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 2537 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate of	Death		Reg	ı. No.		
Physicia Prical Exami	in/	Decedent's Name (First, Middle,Last)	ALICE CRO	CETTI			2. Date of Death Month August 1, 2	Day Year 2008	3. Time of Death 1108 hrs	
	ı	4a. Facility Name (if not institution, give street 186 Kenwood Road	eet and number)	4	b. City, Town, Pasadena	or Location of De		4c. County of Dea Anne Arunde	el	
Funeral Director		5. Social Security Number 6. Sex 216-86-6968 1 M	7. Age (In yrs. 2 4	last birthday) 6 Yrs.	If Under 1 Y Months D		din.		Birthplace (State or Foreign Country) Iaryland	
nd show any	7	Usual Residence of Decedent 10a. State 10b. County MD Anne Ar		, Town or Locati					10d. Inside City Limits 1 Yes 2 No	
n the Maryland 3a or 28a-f show otified at once.	Director	10e. Street and Number 186 Kenwood Roa			10f. Zip Code		10	g. Citizen of What Co	ountry?	
ter death with	Funeral	11. Mantal Status 1 Never Married 2 Married 1 Widowed 4 Divorced If You	. Was Decedent Ever in L Armed Forces? Yes 2 No as, Give Year	If Y		oan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	White, etc.	erican Indian, Black, 	
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only h	Dates:	16a. Deceden during mo	t's Usual Occu ost of working I	pation (Give kind life. DO NOT use		16b. Kind of Busines	s/Industry	
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medical	Be Com	12 17. Father's Name (First, Middle, Last) Daniel Crites		Busir	ness O	18.Mother's Na	ame (First, Middle, M Ces Kess	,	irant	
MD 21 rd 2 should thand Mer m 27 is man aumatic ev	۵	19a. Informant's Name/Relationship (Type, Christopher Croc		(2)				ber, City or Town, Sta ena, MD	11/1	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite ev		20a. Method of Disposition 1 Burial 2 Cremation 3 I	20b.	Place of Dispos crematory or oth	ition (Name of ner place) Cremat	cemetery,	Date 8 / 0.5 / 0.8	20c. Location - City	or Town, State	
Baltimore permit. Pages 1 Department of F Important: If		4 Donation 5 Other Specify: 21. Signature Funeral Scrice Licensee 22. Name and Address of Facility G.J. Gonce Funeral 169 Riviera Drive, Pasadena, MI								
Physician ′Medical ₌xaminer		23a. Part I. Inter the disease, or complicat failure. List only one cause on each limmediate Cause (Final disease a or condition resulting in death)	Seizure Dis	order	ne mode of dyi	ng, such as cardi	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death	
-		Sequentially list conditions, b	to (or as a consequence Gunshot to	head						
	Examiner	causs. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence						-	
ecuted and transit		a.								
760, cate be executed physician and the burial - trans	Medical	IF FEMALE: 2	3c. If yes, outcome of pre		r per i		7 10 00 V	23d. Date of deliv	rery	
Box 687 e death certific the attending p	Physician/									
, P.O. Bc ires that the des signed by the z	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	underlying caus	se given in Part I.			to the cause of death?	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I	Completed						24a. Was a autops perfor	sy prior med? death		
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient 2	ER/Outpatient		Other No		Residence 6 🗸 Ot	her: Scene	
ion of Vending Pheath.	-1	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year) 9-23-2004	28b. Time of I	4	Injury at Work? Yes 2 X No	28d. Describe h	now injury occurred		
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify) unknow		et, factory, offic	ce building, etc.	28f. Location (S or Town, St	tata)	Rural Route Number, City	
29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 100 Details and manner as stated. 100 Details and manner as stated. 100 Details and manner as stated. 100 Details and due to the cause(s) and manner as stated.								tated. the cause(s)		
	Me	29b. Signature and title of certifier	1. 1			ense number C.M.E.		29d. Date signed (
		30. Name and address of person who com Jack Titus MD. Deputy Chi	pleted cause of death (Ite ef Medical Examine		nn Street, E	Baltimore, MD	21201			
Si Regis	tate	ALLES VI 4 ZUUL	32 Registrar's Signa	# A	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 3:15 P. 2008 Dorothy Florence Dumhart August 4, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hopsice, Dove House Westminster If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 215-07-6498 11, 1912 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland Carroll Manchester 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 3438 Viewridge Circle 21102 America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No "natural", or Specify Specify: White XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Technician Catalyst Research 8th or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental H is marked John Dunnigan Helena Madora Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other trauonce. 3438 Viewridge Circle, Manchester, Maryland 21102
ce of Disposition (Name of Date 20c. Location - City or Town, State Sylvia Anuszewski (Daughter 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Waugh United Methodist August 8, 20a. Method of Disposition **Burial 2 Gremation 3 Removal from State 4 ☐ Donation (5 ☐ Other (Specify) Glen Arm, Maryland 2008 Church Cemetery 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A.
3296 Charmil Drive, Manchester, Maryland 21102 Signature of Funeral Service Licensee 2. a. Part. Inter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Accident dise se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HBP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician s the burial Physician/Medical ass attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 XNo 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown <u>Congestive Heart Failure</u> certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes XX No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1XXVatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours al

To the Funeral C

completely filled i Hospital **CXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

Y

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Surendra D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Morjaria,

29c. License number

D17076

M.D., 3000 Manchester Road, Manchester, Maryland 21102

29d. Date signed (Month, Day, Year)

August 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** RUBINETTE LEE DOLAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner ANNE ARUNDE BALTIMORE WASHINGTON MED CTR GLEN BURNIG md 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/24/1915 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😿 F Director 215-01-0805 Virginia Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d Inside City Limits 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7752 Middlegate Court 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married ច់ 1 ☐ Yes 2 No Be Completed by Specify. 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Ire Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Benjamin Slater Blanche Haynie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Fleishell/Daughter 7752 Middlegate Court, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Pk 08/06/08 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode, if dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 🗀 Yes No. 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an has autopsy perform Yes 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Manner of Death 28b. Time of injury 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death filled in by the Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar Name and addres

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onperson who completed cause of death (Item

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			For State	State of Ma	ryland		partment of I			ntal Hy	gien		0	25	271
			Registrar 1. Decedent's Name (First, Middle, I	(act)			ertificate of	Deati		Date of De	Reg. No	<u>. 200</u>	0	3. Time of	37L
	Physicia		JOAN PA	TRIC A		DA	Ivic			Month	Da	ay Yes	antina III	11:20	
	/Medio Examin		4a Facility Name (If not institution,	give street and number)			4b. City, Town, c	r Locatio				c. County of D			
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or l	_ocation						100	d. Inside Cit	ty Limits
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	r 28a	Directo	10e. Street and Number		241140	VCI	10f. Zip Code				10g. C	itizen of What	Countr	y?	
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	ems deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13	B. Was Decedent of I	lispanic (Origin? (Specif	y Yes or No	o-	14. Race - A Black, W			
0030	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ant, the Middeal Evan, or must be instiffed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		lo		1 □ Yes 25 No	Speci		, 0.0.7		Specify:		lack	
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aua'	al Hyg othe	BeC	17. Father's Name (First, Middle, La	st)	,			18. Mo	ther's Name (F	irst, Middle	, Maide	n Surname)			
<u>a</u>	Ments Ments arked	2	Clarence Skinner					Cla	rice Mi	nter					
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. M. droil Exp., in count to make a once.		19a. Informant's Name/Relationship Wade Skinner/Bro						Number or Rural Route Number, City of ace SE, Wash DC 20				e, Zip C	lode)	
e G	of He		20a. Method of Disposition		20b. Plac	e of Dispeterv. cr	position (Name of ematory or other pla	ce)	July Date	28	20c. l	Location - City	or Tow	n, State	
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	eparti eparti porti y inj		21. Signature of Funeral Service Lic	ensee			22. Name and Addre								Inc
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. I e.	Do not e	nter the mode of dyi	ng, such	as cardiac or r	espiratory a	arrest,		1	Approximate Interval Bet Onset and D	ween
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ja. SEPT	70		to ck						2	DA	45
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ם ם	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at	2 ☐ Fetal de	ath 3	Ectopic pregnand	Су			Î	23d. Date of Month		•	Year
5	ding Physician: The law requires that the death certif. h. further this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/M	1 □Yes 2 🖾No 9 □ Unknown	9 ☐ Unknown	time or deal		o⊟ Ottlei (specify) _								
Ţ	that ned b deta		Part II. Other significant conditions	s contributing to death bu	it not resultin	g in the	underlying cause giv	en in Par	rt I.	23e. Did	tobacco	use contribut	e to the	cause of d	eath?
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination	dge, de and/or	ath occurred at the tinvestigation, in my	ime, date opinion, c	and place, and death occurred	d due to the at the time	e causei , date ai	(s) and manne nd place, and	r as sta due to t	ited. the cause(s	:)
	Vithii To th	Me	29b. Signature and title of certifier	(h) ORXA	_		29c. Licens	se numbe	er		29d. D	ate signed (M	onth, D	ay, Year)	
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	4		30. Name and address of person wh		eath (Item 23	Ba) (Type	e, Print) 800	7 R	IVEK	GA	TE	LN	,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2008 '/e /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner ndaustown ltimas If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex (In yrs, last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 F Yrs. -20-Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Evandrer must be notified at 1 ☐ Yes 2 No Director convice 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 833 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 2No Specify: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16h Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be elen UVALL ပ Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typę. Print) niere Health a eto, mai rwentolyn item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition = 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or once. Vet. Aug. 8,2008 4 ☐ Donation / 3 ☐ Other (Specify) 21. Signature of uneral Service Licenson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ALZEIMM ERS /Medical Due to (or as a consequence of): Examiner MAZNUTRITION Sequentially list conditions, if a. y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed CONGESTIVE HEART Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an autopsy 1 □Yes 2 **X** No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 0006143 TO 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) RANDALLSTOWN, MD ADE-16MISI 5311 DLD COURT RD SANYA m. 7 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 7 2008 Registrar Consider !

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Faton MUGUST 2008 culture 10:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 214-44-4245 1 □ M 2 Months March 8,194 2 6 mary Director land Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show 1∕XYes 2 No Funeral Director ITIM ore 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Ø 2121 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Completed by 3 ☐ Widowed 4 Sivorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 27 is marked other than traumatic event, the M. Elementary/Secondary (0-12) omes Oth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 OUISE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 g Department of Health a Important: If item 27 is any injury or other trau once. Slade daughter 8 St. Max 01 21613 -00150 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 9-08 Randall Stown, mD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Strvice/Lice 21229 23a. Part I. 5 / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death FEW HOUR Immediate use (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CARDIOGENIC Examiner SHOCK 16 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit HOURS ACUTE MYOCARDIAL INFARCTION 36 Due to (or as a consequence of): P.O. Box 68760, 36 HOURS RETROPERITONEAL BLEED Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, **≙** 1 Yes 2 No 3 Probably 4 Unknown ACUTE LIVER FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ACUTE RENAL FAILURE autopsy perform 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Sign

AUNI.

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

DRIVE

OSLER

29c. License number D35453

TOWSON, MARYLAND

Pate signed (Month, Day, Year)

21204

and manner stated.

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

BARR,

Physician /Medical Examiner

Director

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burialattending physician for use as the buria Division or Vital Records, P.O. Box 68760 the signed by has been s ae 2 should certificate this funeral After Director: ,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 8/6/2008 Day Mary Alma Franklin 1:00 Ам 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center Westminster Carroll if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/19/1928 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2574 214-28-5036 79 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Item 271s marked other than "natural" or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes StNo New Windsor MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Church St. 21776 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Springfield Hospital Ctr Food Service Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Fred A. Franklin Julia A. Hooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Garver/POA 4731 Ridge Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Carroll Crematory 8/7/08 4 ☐ Ponation 5 ☐ Other (Specify) Winfield, MD 21. Signature of Funeral Service License Barrer-Queenfatuneral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 Part . Enter the diseas shock, or heart failure. e, or complications List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mediate Cause (Final EMBOLISM PULMONAR ng in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral D

Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) MAGAM 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death %%6/200⁸୬ **Physician** 11:02 AM Roland L. Fritz, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Davs Hours 1**%** M 2 □ F 5/20/1933 MD Director 220-26-5317 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21157 3342 Marston Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2/20No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government **USDA** permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event. 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Little Millard Fritz ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3342 Marston Rd., Westminster, MD 21157 Dorothy Fritz/Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Meadow Branch Cemetery 8/9/08 Westminster, MD Burrier Office From Puneral Home & Crematory, P.A. of Funeral Service Ligo 21. Sign uur 1212 W. Old Liberty Rd., Winfield, MD 21784 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part 1 Enter the disease, or shock, or heart failure. List only one cause mmediate Cause (Final **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) I □Yes 2 □ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 TNO 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Of Other (Specify) 1 ☐ Yes / 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 🗂 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 0

SOUTH

29a. Certifier

29b. Signature a

ENTER STREET

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Maching Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WESTMINSTER MO 2115

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of i		rentai myg Re	eg. No. 2008	25379
	Physicia	an	1. Decedent's Name (First, Midd Manuel	le, Last) Max	Farb	er		2. Date of Death Month July 3	1 , Day 2008 Year	3. Time of Death 9:10 AM
- mary	/Medic	al	4a. Facility Name (If not institution		raibe		r Location of Death	July J	4c. County of Deal	
	Examin	er	7613 Royal Do			Bethes	sda		Montgom	ery
	Funeral Director		5. Social Security Number 031–12–4135		86 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 27	9. Bir 1922 Ne	thplace (State or Foreign ountry) Ew York
	land ow		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation		,		10d. Inside City Limits
	Mary	햕	FL Palm	Beach	Boca Rat	on				1 □X/es 2 □ No
	or 28,	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a (23a ust b		8261 Summers			33496			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Incideal Examinat must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 IXWidowed 4 □ Divorce	If Voc Give	10	. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 1 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
altimore, Maryland 21215-0036	n 72 hour "natural	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	nation during most of work d)	ing	16b. Kind of Business	
212	l within giene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+) .	orney			Law	
פר	e filed al Hyg other	Be C	17. Father's Name (First, Middle	, Last)			18. Mother's Nam		Maiden Surname)	
ylaı	Menta Menta arked artic e	10 10	Harry Farber				Sarah S			
Jar	2 sho hand risma raum		19a. Informant's Name/Relation Arlene Farber						, City or Town, State, esda. MD	Zip Code) 20817
e)	1 and Healt em 27		Arlene Farber 20a. Method of Disposition	Sirkin (Daug	20b. Place of Disp	position (Name of ematory or other place	, i	Date	20c. Location - City or	Town, State
nor	ages ent of tt: If it y or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ematory or other plac Litan Cren		1. 08	Alexandri	a, VA _
Ħ	mit. P partme cortan injur		21. Signature of Funeral Service			22. Name and Addre	ess of Facility		_	FL
m	Der Jany		23a. Part 1. Enter the disease, o shock, or heart failure. Lis	Velton		_ •				Pompany Bea
	Iticate be executed / Medical Physician and / Medical street is the prulat-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b	Cancer, M a consequence of): a consequence of): a consequence of):					
	ath certi attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2□No 9 □Unknown	23c. If yes, outcome 1	2 Fetal death 3	B	су		23d. Date of de Month	elivery Day Year
ds, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant condit	ions contributing to death be	ut not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute t es 2፟፟፟∑ No 3☐ F	o the cause of death? Probably 4 \(\square\) Unknown
မ	law as b	Completed	25. Was case referred to medic				26. Place of Dea		med? death? 2 ☑ No 1 ☐ Ye	utopsy findings available completion of cause of s 2 No
on of Vii	Attending Physician: The la r death. ector: After this certificate ha: by the funeral director, page 2	tion: To Be	examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pend	Hospital: 1 Inpatie		of 28c. Inju	ner: 4 🗆 Nursing H	ome 5 ☐ Resid		Daughter's ^{eci} Residence
Divisi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: To	3 Suicide 6 □ Could	not be 28e. Place of Injuries	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	• Hospi 24 hour • Funera etely fills	Medical (29a. Certifier (Check only one) **Description* **Description* **Certify* 2 □ Medical Med	Ing Physican: To the best al Examiner: On the basis of and manner st	of examination and/or	eath occurred at the to investigation, in my	ime, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and manner address and duate and place, and du	as stated. le to the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifi	· - /		29c. Licen	se number		29d. Date signed (Mor	th, Day, Year)
			1 XAME	In w		3039	6	J	July 31, 20	800
	5		30. Name and address of perso	9			nia Ave.	NW Washi	ington, DC	20037
	Sta Regist		31. Date filed (Month, Day, Yea AUG 0 7	7) 2008 32. Registr	ar's Signature	and in				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical acility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea **Funeral** Days Min. 1 M 2/2 Months 7-68-0046 Director 2-22-1956 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show notified 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ral", or Items 23a or Examiner must be Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes V No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 Tyes 2**/2**(00 Specify slack Completed by 3 Widowed 4 Divorced "natural" Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. Do NOT use retired) (Specify only highest grade completed) lary (0-12) College (1-4or 5+) 17. Fathe Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname Be 2 nn19a Informant's Name/Relationships//I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) inter 10. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lice 23a. Part1. Enter the disease shock, or heart failure. sease, or complications that caused the death. Do not enter ure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 □ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No Other: 1 Yes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending Accident death. investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who d

AUG 0

31. Date filed (Month, Day, Year)

RATMOS, MD

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25381 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^{Year} **Physician** AUGUST YALE FRIEDLANDER 3:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1 SLADE AVENUE, #601 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/23/1922 5. Social Security Number 6. Sex 1 Ø M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-14-0728 85 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 □Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 SLADE AVENUE, #601 21208 USA Funeral death . Was Decedent Ever in U.S. Armed Forces? 1 AVes 2 □ No ARMY IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) OWNER CLOTHING MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY FRIEDLANDER LILLIAN FREEDMAN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY FRIEDLANDER / WIFE 1 SLADE AVENUE, #601, BALTIMORE, MD 21208 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of ANS Cameter), stampacy or other place) Date 20c. Location - City or Town, State Department of Important: If any injury or once. 08/06/2008 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC PROST ATF disease or condition resulting in death) 17-YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause (Disease or injury that initiated events resulting in death) Last Examine Day to (or as a consequence of) be executed burial-transi Due to (or as a consequence of) Box 68760; attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the ☐Yes 2☐No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 1 □Yes 2 🗆 No 2 [1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner?

1 Yes 2 No

Manner of D at

1 Natural

2 Accident Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after use.....
To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Registrar

1650 ORDEMUS 31. Date filed (Month, Day, Year)

29b. Sigr

BALLITONE 1M.51

and manner stated

ne and address of person who completed cause of death (Item 23a) (Type, Print)

81.

29c. License number

078768

Orn

21231 -1000

29d. Date signed (Month, Day, Year)

8/05/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day WILLIAM **GEORGE** GRAY 5,2008 AUGUST 1:35A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 6601 RIDGE ROAD ROSEDALE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-28-1936 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F Months Days Hours 219-32-1426 MARYLAND 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 No MD ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6601 RIDGE ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER BALTIMORE CITY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SR. WILLIAM G. MARIE IDA (DERDA) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY BURGESS/DAUGHTER 6601 RIDGE ROAD ROSEDALE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-8-08 BALTIMORE, CEMETERY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 21. Sonatura of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner sician and burial-transit Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a find the sortier or items and injury or other traumatic event, it as find the sortier or items the sortier of the sortier of the sortier or items.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

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cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque	IVE H	THE FA	lure		
ysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1	eath 3 Ectopic			23d. Date of deliv	<i>r</i> ery Day Year
Completed by Physician/Medical Examiner	Part II. Other significant conditions con INSULIN DEP CHRONIC REN HYPERTEN	AL FAILUR	BETES 1	cause given in Part I.		2 No 3 Pro 24b. Were auto prior to co death?	the cause of death? bably Unknown opsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3 ☐ [ath (Check only one) Home 5 Residence		
Medical Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ry, office	and Number or Run ate)	al Route Number,	
edical	29a. Certifier (Check only one) Certifying Phys 2 Medical Examir	clcian: To the best of my knowl ner: On the basis of examination and manner stated.	edge, death occurre in and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)
M	29b. Signature and title of certifier	Les.	25	9c. License number	Α.	Date signed (Month,	~

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Leo Joseph Garvey August /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Itospita Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs 8. Date of Birth Noveth, Day, Year 1930 If Under 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□F Months Days Hours Maryland 216-28-6107 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Director Halethorpe 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5737 Mineral Ave. 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 195
If Yes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1950-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1954 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Lineman Installer</u> Telephone Company 17. Father's Name (First, Middle, Last)
Leo Joseph Garvey, 18. Mother's Name (First, Middle, Maiden Surname) Be Srll Theresa Keene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Garvey, wife 5737 Mineral Ave. Halethorpe, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Veterans Cemetery
of Crownsville 20a. Method of Disposition 20c. Location - City or Town, State Bunal 2 □ Cremation 3 □ Removal from State 08-07-08 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Ambrose Funeral Home, I
1328 Sulphur Spring Rd. 21. Signature of Funeral Service Licensee 0 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O Cara 30m1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Division or 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation n 24 hours after death.

he Funeral Director: A
pletely filled in by the fi 1 🗌 Yes 2 Accident 2 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

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2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Hugust **Physician** Day 9:35AM Marvin Gaine 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice - Northwest Randalls town Slasons Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours 219.38.063 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits f show other traumatic event, the Medical Examinar must be notified at Director Baltimore MD 1 □Yes 2 No Windsor Mill 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 2124 20 Avenue Funeral dinards 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Modicel Examina 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation IVUCK Driver 12th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Thompson Charlie Gainey ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avenue Windsor Mill MD 21244 Gainey 6720 Edwards lanet 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 08/08/08 Memorial Park Windsor Mill, MD 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee ans 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Congestive Heart Failure /Medical Due to (or as a persequence of Examiner Due to (or as a consequence of): Securitizity is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: SGYSCAUS HOSPILL 1 Tes 2 No Other: 4 \square Nursing Home 5 $\underline{\square}$ Residence 6 $\underline{\square}$ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 💹 Natural within 24 hours after death.

To the Funeral Director: A 2 Accident 1 □Yes 2 🗆 No filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 REISTENSTOWN MD MAIN STREET

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) GReif 11 03 PM S008 **Physician** 04 026bD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE OWINGS MILLS 104 PLEASANT RIDGE DRIVE, APT. 214 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 08/04/1914 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours NY 94 093-10. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show Item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the "Actical Examiner must be notified at 1 □Yes 2 No Completed by Funeral Director BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 104 PLEASANT RIDGE DRIVE, APT. 214 21117 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 🔏 If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 □Yes 2 🛣 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE INSURANCE AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN SADIE GREIF WILLIAM ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any Injury or other trau 104 PLEASANT RIDGE DR. #214, OWINGS MILLS, MD 21117 SYLVIA GREIF / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/06/2008 FINKSBURG, MD BETH JACOB CONG. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Le 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. congestive cardiomyopat Immediate Cause (Final Schemiz **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ANTY Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □No Division of Vital Records, P.O. 9 Unknown g 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No Certification: To 1 Yes 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical one) and manner stated 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randonstown 8600 Walters Lybert 31. Date filed (Month, Day, Year) State 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1000 M HERRMANN FREDERIUL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Tate Hospice House Linthicum Heights If Under 1 Year If Under 24 Months Days Hours 8. Date of Birth Month, Day 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 89 160-05-6667 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2X No Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 205 S. Haven Street 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWT] 14. Race · American Indian

1 ☐ Yes 2 ▼ No

16a. Decedent's Usual Occupation

Store Manager

20b. Place of Disposition (Name of cemetery, crematory or other place)

WWIT

son

College (1-4or 5+)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Media

923 Redmore Drive, Severn, MD

(Give kind of work done during most of working life. DO NOT use retired)

Black, White, etc.

Specify: White

20c. Location - City or Town, State

Baltimore, MD

16b. Kind of Business/Industry

Retail

18. Mother's Name (First, Middle, Maiden Surname)

Box

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

11. Marital Status

Otto

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifier

Name and address of person

31. Date filed (Month, Day, Year)

29a. Certifier

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

Herrmann

Frederick A. Herrmann, Jr.,

1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

08-05811 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Harry Emanuel Hnarakis State of Maryland / Department of Health and Mental Hygiene 25387 Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year Month Day July 29, 2008 1750 hrs Medical Examiner Harry Emanuel Hnarakis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1700 Jarvis Avenue Oxon Hill 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under Year If Under 24Hrs. **Funeral** Foreign Country)Virginia Director Months Davs Hours Min. 224-22-9865 1 X M 2 82 Yrs July 3, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at once.</u> Yes 2 X No Oxon Hill Prince George's Maryland more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 20745 USA 1700 Jarvis Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 tant: If item 27 is marked other than "natural", or i or other traumatic event, the Medical Examiner mu Specify: White Yes 2X No specify: 3 X Widowed If Yes, Give Yea 1943-1945 Divorced þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aeronautical Engineer Self - Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vasiliki Gianakakis Be Emanuel Hnarakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Athena Hnarakis, Daughter 35530 Scottsdale Circle Laurel, DE 19956 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 crematory or other place) Removal from State permit. Pages
Department of
Important; It Metro Crematory Inc. 08/07/08 Baltimore, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 Physician 23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease ~xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - tran Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year detached for use as past 12 months Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown icate has been signed by t page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 1 Yes No Hospital or Attending Physician: 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other 4 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 7 No 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No hours after death. Pending To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical (Check only 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 30, 2008 10 30. ame and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatur **State** 2008 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and	l Mental Hygie	ne 2008 25388
			1 - State Certificate of Death	Reg.	No. 2000 23300
	Physici /Medic		1. Decedent's Name (First, Middle, Last) APRIL 1+4 MAN	2. Date of Death Month	Day Year 72 3 70 M
1	Examin			ath	4c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		O Pirthplace (State or Foreign
	uneral irector		213-84-6241 1 M 2 K 45 Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign Country)
yland	MOI TH		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
he Mar	28a-f sł	ector	MD NIA Baltimore		1 Yes 2 No
ath with t	23a or 3	Funeral Director	10e. Street and Number 21212		Citizen of What Country?
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	event, the Medical Examinational by notified at	þ	3 ☐ Widowed 4 ☐ Divorced	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACC
215-0 hin 72 ho e.	Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	orking 16b	. Kind of Business/Industry
12121 led within 7	her th	Con	12 Cashier		techingers
Maryland d 2 should be file th and Mental Hy		To Be		ame (First, Middle, Maid 2+++e=D	den Surname) AVIS
	7 is trau		19a. Informant's Name/Relationship (Type. Print) Annette Ityman, Mother 6225 YORL ROHINT	_	ity or Town, State, Zip Code)
S - E	nt: If item 2 ry or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	Location - City or Town, State
Baltii permit. F Departm	Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Lowell	Funeral Home
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardio	1 100	70. NO 21207 Approximate
	sician edical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RAND TENTORIAL HERNIAT.	1010	Interval Between Onset and Death
	miner		Due to (or as a consequence of): CEREBRIL EDEMA		
Scuted St	nd ransit	Examiner	It any, leading to limited late cause. Enter Underlying Cause (Disease or injury that initiated events C. MALTI ORGAN FAILURE		
60 , % be executed	physician and s the burial-transit				
ox 68760, certificate be ex	g phys	edical			
g fg	by the attending pached for use as f	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
S, F.	gned b	by PI	Part I. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord requir	een si			1 ☐ Yes	2 No 3 Probably 4 Unknown
VITAI KECORUS, ilcian; The law requires tl	cate has b page 2 st	Completed	MORBID OBESITY	24a. Was an autopsy performed	
VIT	certifi rector,	Be	25. Was case referred to medical examiner? 26. Place of De	eath (Check only one)	
D Phys	er this eral dii	۳: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Residence	e 6 Other (Specify)
ath.	or: Aft	atio	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
DIVISION If or Attending after death.	Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, St	t and Number or Rural Route Number, late)
DIVISION OT VITAL HECONDS, P.O. To the Hospital or Attending Physician: The law requires that the dr within 24 hours after death.	e Funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and manner stated.	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th within	To th	Me	29b. Signature and title of certifies 29c. License number		Date signed (Month, Day, Year)
			1. M.D. RES-200		lug 6, 2008
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WYEL HAKM 5601 LOCH RAVEN BLUD	Raition	DRE, MD 21239
	Stat		31. Date filed (Month, Day, Year) 32. Repistrar's Signature	1 01101)110	01231
F	Registra	ar	AUG 0 7 2008 Region In Angell 3		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** eanard 2:00 A M 2008 541 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death Seasons Hospice - Northwest an dall stown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Hours Date of Birth (Manth, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 1 XM 2 ☐ F 218-60-4748 Director 01/201 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Predical Examiner must be notified at Ballimore Windsor Mill Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Southgreen 3209 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm In any injury or other traumatic event, I'm In any once. Elementary/Secondary (0-12) College (1-4or 5+) Latering Compan Manager 11th grade 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surnan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windsor Mill MD 21244 Debra Hamlin Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 08 Baltimore, MD 06/08 22. Name and Address of Facility Voughn C. Greene Fiveral SVCS 21. Signature of Funeral Service Licensee 8728 Liberty Road Randall stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Find Stage HIV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2☐No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? >LH SCN'S Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ITOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) une 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debarah 25 MAIN STREET REISTERS TOWN Registrar's Signature 31. Date filed (Month, Day, Year) State 2008

Registrar
DHMH 17 Rev 1/2001

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amend item 1 per doc 882 8-7-08 vt.
State of Maryland Poppartment of Health and Mental Hygiene
5 per Inf G884 10/2/08 Tarrificate of Death

Bed. No. 2008 1- State Amend #5, perInf G884 10/2/08 Tertificate of Death 25390 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ye ar Month MARGUIE Maggie B. Hornes PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMERE If Under 1 Year | If Under 24 Hrs. MADISON 400 ST APT 611 NIA 5. Szij fecurity Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. -12-8150 Yrs. Director MAY 6 1922 V.A Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, I'm Medical Experiment roughly notified at once. BALTIMORE **Funeral Director** 1 Nes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 21205 U.S.A MADISON ST Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12713 2725 RETURED NURSONG HOORE 1STIGHT -17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FINA ၉ nomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARDIE A DICLAC 17VE BALTIMORE MD 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 218/08 OUDEN PARK CEM 3620 Wicewarz BALTO 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BETTS FUNDRAL AIRI ST BALTE 1129 N CARGUNE mD 31213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Acute myo CARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner the Those Cometone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): physician and s the burial-transit 13/10 510M be exect resulting in death) Last Due to (or a a consequence of): Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s certificate of Vital 2 No 1 ☐ Yes 2 PNo 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
Natural
2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Definition Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 3040 ss of person w eath (Item 23a) (Type, Print) 32 Registrar's Signature 100 - manual B wastri 31. Date filed State 2008

Registrar

Este.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LEAH NICOLE HARTLOVE 07:30 PM 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months 1□M 2 F Hours Min. N/A Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD 1 □Yes 2 No Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 711 Wesley Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à If Ves Give Specify Specify: 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stacy Hartlove Dannyell Darby ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Wesley Rd, Glen Burnie, MD 21061 Mother Stacy Hartlove 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview drematory Aug 6, 2008 4 Donation 5 ☐ Other (Specify) Baltimore, MD uneral Survice 22. Name and Address of Facility Fink Funeral Home, P.A. 21. Signally Gregory Fin M1148 426 Crain Hwy S, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** COMPLETE SMALL BOWEL NICROSIS /Medical Due to (or as a consequence of): Examiner NECKOTIZING ENTERO COLITIS Sequentially list conditions, if any, leading to infine underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offi law requires that the death certificate be executed 20 days EXTREME PREMATURITY & VERY LOWBIRTH WETGHT and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy perform certificate 1 🔲 Yes 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YANGALASETTY CHANDRASEKHAR 31. Date filed (Month, Day, 32. Registrar's Signature District. State AUG O Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 800 AM Esther Roberts Jackson Aucust 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Hospital N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Director APR 12, 214-16-8037 Usual Residence of Decedent 1915 Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor Injury or other traumatic event, the Medical Exart in a rust be notified at Director 1 TYPY 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with tond Mental Hygiene.

marked other than "natural", or items 23a or 2 5023 Pimlico Road 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No þ If Yes, Give Year or Dates: Specify Specify: Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Dept of Social Services permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Johnson Mary Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nathaniel Jackson/Son 5023 Pimlico Rd Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 8/5/08 Baltimore, MD Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclaroti-c disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Corpestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and physician ar Due to (or as a consequence of): Box 68760; Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the a □Yes 2 No 9 I Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 □ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number mon -OKire 031861 30. Name and address of person who complefed cause of death (Item 23a) (Type, Print) Baltimore Centar Street 206 OV 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend iseme of Maryfahos 85 partment 98 Health and Mental Hygiene 25393 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 29,2008 Melvin Emmanuel Jones 10:41 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Numb | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1958 | 9. Birthplace (State or Foreign (Month, Day, Year) | Washington DC 7. Age (In yrs. last birthday) 49 vrs Funeral XXM 2 F Months Director Washington DC Usual Residence of Decedent 10b. County 10a. State 28a-f show 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, I'm Medical Evantiner must be notified at 1 ∏Yes 2 ☐ No Director Maryland |Prince George's Oxon Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Hampton Drive 20745 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Event 1 □Yes 2,□No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Black à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelth None Cook Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be |Melvin Jones Sr Dorothy Yates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Yates/Mother 621 Hampton Drive, Oxon Hills MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Suitland, Maryland August 5, 2008 Washington National 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar resulting in death) Last Due to (or as consequence of Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 2 🗆 No 1 □Ýes 2 2 100 1 ☐ Yes After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Certification: To 20 TNo Inpatient 2 ER/Outpatient 3 DQA 27. Mann 1 atural Date of Injury (Month, Day, Year) eath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical xaminer; Our the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signatur

31. Date filed

bo completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ac

Suc

29d. Date signed (Month, Day, Year)

08-0	59	18	
Ava	M.	Johnson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

va w. Johnson		- For State	Certificate of	r Health and Mental Hy f Death		g. No. 200	8 2539	
Physician Medical Examine	1/	1. Decedent's Name (First, Middle,Last)				n	3. Time of Death 1142 hrs	
nedicai Examini		Ava M. Johnson 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	Month August 2, 2	4c. County of Death		
4	4	Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Berlin If Under 1 Year If Under 24Hrs	8 Date of Birth	Worcester h(MM/DD/YYYY) 9. Bir	tholace (State or	
Funeral Director		202.82.4665 1_M 2XXF	2 Yrs	Months Days Hours Min.		Foreig		
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Local	tion		······	10d. Inside City Limits	
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th the Maryland 23a or 28a-f sho notified at once	Dire	10e. Street and Number 408 Clifton Ave		10f. Zip Code 19023	10	og. Citizen of What Cou USA	ntry ?	
death witl	Funeral			as Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,	
irs after ural", miner	ᇍ	Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade compared to the comp	11	Yes 2XX No specify: nt's Usual Occupation (Give kind of v	vork done	SpecifyWhite 16b. Kind of Business/	Industry	
215-0036 be filed within 72 hours after death with the Maryland that Hygiene. Fred other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5	during n	nost of working life. DO NOT use reti		N/A		
		17. Father's Name (First, Middle, Last)		18.Mother's Name	•	Maiden Surname)		
S P S S	To Be	Francon Johnson 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Helen Ch g Address (Street and Number or I		ber, City or Town, State	e, Zip Code)	
e, MD 1 and 2 sho Health and item 27 is	- [Helena Charlton 20a, Method of Disposition		Clifton Ave, Collingd	ale, PA	19023 20c. Location - City or	Tour State	
		1 XXBurial 2 Cremation 3 XX Removal from Sta	crematory or of	ther place)	8, 2008	Springfield		
Baltimore, permit. Pages I at Department of Hei Important. If the injury or other tr	+	4 Donation 5 Other Specific 21. Agnature of Funeral Service I Centree	22.	Name and Address of Facility Fink Funeral Home, P	.A.		,	
Physician	4	/ N. Gregory Fink \ M01148		426 Crain Hwy S, Gle			Approximate Interval	
/Medical xaminer		Immedi e Cause (Final disease a. COmplications of nurofibromatosis Between Onset Death						
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,							
	Examiner	if any, leading to immediate Cauce. Enter Underlying Cauce (Disease or injury that initiated	equence of):					
ecuted and transit		events resulting in death) Last Due to (or as a consequence of):						
60, ate be exect physician an	Medical	X UNPENDED 23a,27,perME, g883 9/26/08 TT						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor 1 Live birth 24 Pregnant at	2 F	etal death 3 Ectopic pregnather (Specify)	ancy	23d. Date of deliver Month	y Day Year	
Box le death the atte	Physician/	1 Yes 2 No 9 Unknown g Unknown						
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. The Table of the serificate has been signed by all Director: After this certificate has been signed by the funeral director, page 2 should be detached in the funeral director, page 2 should be detached.	ক্র	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	1 Yes	bacco use contribute to	bably 4 Unknown	
cords,	Completed				24a. Was a autop: perfor		utopsy findings available completion of cause of	
ital Recician: The scertificate rector, page		25. Was case referred to medical		26.Place of Death (Check	1 Yes		es 2 No	
Vita hysician this cer	To Be	examiner?	nt 2 🗸 ER/Outpatien	Othor:		Residence 6 Othe	er:	
sion of Valending Phydeath. ctor: After thy the funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	ear) 28b. Time of	Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	now injury occurred		
Division of At hours after duneral Direct y filled in by	Certification:		jury - At home, farm, stre	eet, factory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City	
To the Host within 24 ho	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day,Year)	
		30. Name and address of person vno completed cause of d Jack Titus MD. Deputy Chief Medical E		nn Street, Baltimore, MD 2	1201			
Sta Registr	te		r's Signature	.M.s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J		
State of Marylar	nd / Department of He	ealth and Mental Hygiene

2008 25395

		1- For State Certificate	g. No.					
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year 0040 has			
al Examir		Edward Kaminski 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	August 4, 2	4, 2008 0912 111S			
		Franklin Square Hospital	Rosedale		Baltimore County			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	·		h(MM/DD/YYYY) 9. Birthplace (State or			
Director		$217-40-9106 \qquad _{1 \times M} \qquad _{2} = 65$	Yrs. Months Days Hours	6 Man. May 17	Country) MD.			
		Usual Residence of Decedent			10d. Inside City Limits			
ow any	ı	10a. State 10b. County 10c. City, Town or I Md. Baltimore	Dundalk		1 Yes 2 X No			
aryland 8a-f show at once	햙	10e. Street and Number	10f. Zip Code	T 10	Og. Citizen of What Country?			
th the Maryland 23a or 28a-f sho notified at once	Director	527 S. 45th Street	21224	"	USA			
with the ms 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Original		14. Race - American Indian, Black,			
death er iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 M No	If Yes, specify Cuban, Mexican Yes 2 X No specify:		White, etc.			
s after ral",	2	or Dates:		Specily.				
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D36 thin 7 ne. than	Completed	12 Years	Data Processing	Г	Crown Cork & Seal			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last) Edward Thadeus Kaminski		r's Name (First, Middle, N	'			
121 d be fi fental arked	Be			a Francis P				
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she gumatic event, the Medical Examiner must be notified at once	우		42 Manor Road,		nber, City or Town, State, Zip Code)			
e, M and 2 Health item 2 traut	ŀ	20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery,	Date	20c. Location - City or Town, State			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation 3 Removal from State St. Star	or other place) nislaus Cem.	August 9, 2008	Baltimore City, Md.			
Baltir permit. I Departmo Importa injury o	ł	21: Signature of Funeral Service Licensee	22. Name and Address of Facilit	у	1 11			
w 52 7 11 11		Aln Exel y	Connelly Funera 7110 Sollers P	n Home OI D Point Road,	undalk P.A. Dundalk, MD, 21222			
`hysician Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and						
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	Disease		Death			
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	if any, leading to immediate Due to (or as a consequence of): Course. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):							
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18760, tificate by ing physic as the bur	Ž.	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectop	ic pregnancy	23d. Date of delivery Month Day Year			
Box 68: death certif	Physician/Medical	4 Pregnant at time of death 5	Other (Specify)					
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+ to feat 6.	lät	2 Accident Investigation	1 Yes 2		2			
Division of Vital Records, tat or Attending Physician: The taw requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	, street, factory, office building, ε	or Town, S	Street and Number or Rural Route Number, City State)			
Hospit 4 hour Funera		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
Divis To the Hospital or Al within 24 hours after Crothe Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
FSFS		29b. Signature and title of certifier	29c. License number	r	29d. Date signed (Month, Day, Year)			
		Mollin Brasse (M) O.C.M.E. August 5, 2008						
10		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
IUSt	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regist		AUG 0 7 2008 Blaker Dr Appeal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 08 Day ANTOINETTE **FRANCES** KUES 1:10 AM 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE None 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Oct 13, 1924 **Funeral** 9. Birthplace (State or Foreign Hours Min. 1□M XXF 218-18-3494 MAryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits Examiner must be notified at XXYes 2 □ No Director Maryland None 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 6100 Everall Avenue 23a 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2**X**No Specify: <u>`</u> White 3 ☐ Widowed XX Divorced d 2 should be filed within 72 hou th and Mental Hygiene. ?7 is marked other than "natural traumatic event, the Machool E. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Drug 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles John Handlir Tinnie Frances Scott ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is rr any injury or other trauronce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank C Kues Son 7009 Bellona Avenue Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery ☐ Donation 5 ☐ Other (Specify) 8/7/08 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Hm Inc Signature of Funeral Syrvice Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** SHOCK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En or unarrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month 4 ☐ Pregnant at time of death Day Year 1 □Yes 2 □ No 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYELODYS PLASTIC SYNDROME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORDNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has DISORDER performed? SEI2URE Division of Vital 2. No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No Certification: To 1 Yes 1☐Inpatient 2☐ER/Outpatient 3☐DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES 000 08/04/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MRN

ANTOINETT

DOB: 10/13/1924

State Registrar 31. Date filed (Month, Day, Year) AUG 0 7 2008

PRACHI JOG

GOOD SAMARITAN HOSPITAL, BALTIMORE 32. gistrar's Signature

			State of Maryland / D				lental Hyg	giene		
		•	- State Registrar	Cer	tificate of l	Death	F	Reg. No. 2008	25397	
	Dhusisis		1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Day Year		
	Physicia /Medic		Joanne		Lewis		August 3, 2008		11:00 A ^M	
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death Prince George		
. • '			4208 Blacksnake Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday)	Temple H	If Under 24 Hrs.	8. Date of Birth	n 9. Birt	hplace (State or Foreign	
	Funeral Director		, □	rs.	Months Days	Hours Min.	(Month, Day Sept.]	8, 1941 Ma	ryland	
7	2		Usual Residence of Decedent		otion				10d. Inside City Limits	
- Para	show	٦ ا	Tou. State						1 □Yes 21♥ No	
Mod	28a-f	Director	Maryland Prince George's Temple	H1.	L.L.S 10f. Zip Code			10g. Citizen of What Co	untry?	
di di	Sa or		4208 Blacksnake Drive		20748			U.S.A.		
aryland 21213-0030	ms 2%	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame		
0	or Ite		Armed Forces? 1 □ Never Married 2 □ Married If Yes, Give		Yes, specify Cuba	Specify:	Hican, etc.)	Black, White		
ocoo	iral",	d by	3X Widowed 4 □ Divorced Year or Dates:					Г В	lack	
ה ל	"nati	Completed	(Specify only highest grade completed)	(Give I	lent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing	16b. Kind of Business/	industry	
7	than	d lie	Elementary/Secondary (0-12) College (1-4or 5+)		ery Manag	*		Food		
D 10	Hyg other ent, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)		
ומו ק	Aenta Aenta rked tic ev	To B	Joseph Edwards Lyons, Sr.			Mary Lo	u Fowlke	es		
ary	and N		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailin	g Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, State, 2	Zip Code)	
Σ ;	ealth m 27 ner tr							111s, MD 20		
ore ore	or off		120 Burial 2 Li Cremation 3 Li Removal from State 1		sition (Name of natory or other plac		Date			
Saltimor	rtmen rtant: njury				emetery . Name and Addre	8/11	/08	Warren, OH		
מ	permit. Pages I am 2 should be been within 72 hours after death with the waryan long-article I Health and Mental Hyghene. Important: If I tem 27 is marked other than "natural", or I tems 23a or 28a-f show any Injury or other traumatic event, the Medical Evaning Function to once.		21. Signature of Funeral Service License	S	terling-N	cCulloug	h-Willia . Warre	ams Funeral	Home	
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot ente	er the mode of dvir	ng, such as cardiac	or respiratory ar	rest.	Approximate Interval Between	
P	hysician	0.0	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition resulting in death)	a C	pulm	MATT	ARRE	5	Onset and Death	
	/Medical		resulting in death) Due to (or as a consequence of	of):		V				
-	xaminer	_	Sequentially list conditions.		11550 W					
7	isit ed	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or):						
	and and al-trar	Examiner	that initiated events c. Due to (or as a consequence of Due to	of):						
ords, P.O. Box 68/60,	cate be executed thysician and the burial-transit	dical E	d							
20	inicati ng phy as the	ledi								
X OX	endin	N/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □	Ectopic pregnanc	:v		23d. Date of de	- 14	
ים כ	he att	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death		Other (specify)	,		Month	Day Year	
ר ל	d by t etach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying cause div	ren in Part I	23e. Did to	obacco use contribute to	o the cause of death?	
ds,	signe	ğ	M/o Aventing & brain	1110 01	idonying dadoo giv				robably 4K Unknown	
ecords,	been should	Completed by	s/p Breast cancer				24a. Was	an 24h Were a	utopsy findings available	
ž ę	e has	Ja m	EMPHYSEWA				autop perfo	osy prior to death?	completion of cause of	
Vitai	ificate		25. Was case referred to medical			26. Place of Dea	1 ☐ Yes		s 2 No	
> 3	s cert	o Be	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatier	nt 3 DOA Oth	or:		dence 6 ☐ Other (Spe	ecify)	
101	g rn ter thi	n:T	(4.4 - 46 - 65 - 77)	Time of	28c. Inju	ry at		how injury occurred		
o i	ath. or: Af he fur	atio	2 Accident investigation		M 1□	Yes 2 □No				
DIVISION	ter de Irecto n by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	rm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or Fl wn, State)	ural Route Number,	
ב	urs at	ပိ	29a. Certifier 1 Certifying Physician: To the best of my knowledge	n doot	h cooursed at the fi	me data and place	and due to the	cause(s) and manner s	ac ctated	
2	To the hospital of Attending Prysician. The law requires that the beant befund with 24 hours. Within 24 hours and the control of the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	d/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)	
4	vithin o the	Med	20h Circoture and title of cortifier		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)	
	->-0		Pelis a Meerin M. D.		D002	4579		August 5, 2	008	
	\wedge		30. Name and address of person who completed cause of death (Item 23a) ((Туре,	Print) 2041 1	Martin Lu				
	1		Peter O. Kwon, M.D.			ngton, DC		_		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature							
	Registr	al	0115 0 7 2008 Fee 2		45					

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narles Frank Ly			nt of Health and Mental te of Death	Hygiene Reg. No	2008 2539					
Physicia I Exami	ın/	1. Decedent's Name (First, Middle,Last) Charles Frank Lynch, Jr		2. Date of Death Month Day August 2, 200	Year 3. Time of Death 0445 hrs					
		4a. Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of De Baltimore	eath	4c. County of Death N/A					
Funeral Director		5. Social Security Number 214-64-7020 6. Sex 1 M 2 F 51		Hrs. 8. Date of Birth (Mr Min. Dec. 19	wDD/YYYY) 9. Birthplace (State or Foreign Country)Maryland					
any	-	Usual Residence of Decedent 10a. State	Location		10d. Inside City Limits					
Aaryland 28a-f show I at once.	ģ		imore	140a C	1 XYes 2 No					
the Mar a or 28a tiffed at	Director	10e. Street and Number 2123 Wilkens Ave.	10f. Zip Code 21223	_	USA					
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu Yes 2 No specify:		14. Race - American Indian, Black, White, etc.					
ours afte (tural", aminer	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent of the complete of the complet	ecedent's Usual Occupation (Give kind	of work done 16b	Specify: Nind of Business/Industry					
1036 vithin 72 ho ene. er than "na Medical Ex	Completed	Elementary(Secondary (0-12) College (1-4 or 5+)	ork Lift Operator	,	Warehouse Worker					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Charles F. Lynch, Srl	en Surname)							
MD 21; d 2 should b Ith and Men n 27 is mar	70	City or Town, State, Zip Code) 1timore, MD. 21229								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State cremator	Disposition (Name of cemetery, y or other place) rundel Crematory	08-08-08	c. Location - City or Town, State Odenton, MD					
Balti permit. Departr Import injury		21. Signa	22. Name and Address of Facility Ambrose Funera 2719 Hammonds	1 Home of I	ansdowne ansdowne, MD. 21227					
ີ hysician Medical £xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Due to (or as a consequence of):	enter the mode of dying, such as card							
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulting in death) Last Underlying Cause (Oisease or injury that initiated events resulti								
e executed sian and rial - transit	<u>_</u>	d. UNPENDED AMENDED								
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be extracted: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delix 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Vision 1 Vis								
rds, P.O. E requires that the d been signed by the	b	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I		co use contribute to the cause of death?					
of Vital Records, P.O. ng Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detacted.	Completed			24a. Was an autopsy performed						
Vital Rechysician: The this certificate	Be C	25. Was case referred to medical examiner? Hospital: 1 Inputient 2 ★ FR/Qut	26.Place of Death (Chapatient 3 DOA Other N							
ion of Vi tending Physl eath. for: After this	ion: To	1 ✓ Yes 2 No	patient 3 DOA Office N ime of Injury 28c. Injury at Work? 1 Yes 2 Ne	28d. Describe how	idence 6 Other:					
Divi	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Corr Town, State)								
To the Hosp within 24 hou To the Fune completely fi	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occur	, and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)					
To vit	Mec	29b. Signature and title of certifier Mun Grasse Masse	29c. License number O.C.M.E.	I .	d. Date signed (Month, Day, Year)					
i		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201						
St Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Scarle 2							

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Jugust Physician 06:00 AM 4a. Facility Name (If not institution, give street and number)

And PITAL OF BALTIMORE 2000 /Medical 4b, City, Town, or Location of Death BALTIMORE C
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. City, Town, or Location of Death 4c. County of Death Examiner Age (In yrs. last birthday) Date of Birth (Month Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director Usual Residence of Decede filed within 72 hours after death with the Marylans 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Baltimore 1 ZYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Baltimore, MD 21215 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -08 Baltimore, MD 21. Signature of Funeral Service Licenses hn C. Areene funerals a Approximate Interval Between Onset and Death 23a. Part 1. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 42011 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or): The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Year Day 4 ☐ Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No. 1 ☐ Yes 2 X No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death

Natural

Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

4 State

Registrar

DHMH 17 Rev 1/2001

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line c Per md G882 8/7/08 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 01, 22AM AUGUS LDWARN OVK 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins - Bayview Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Months Hours 1 XM 2 □ F 217-82-9177 32 Maryland Director September 14,1975 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It would also received any Injury or other traumatic event, It would also any injury or other traumatic event, It would also any injury or other traumatic event, It would also a second any injury or other traumatic event, It would also a second and a second and a second and a second and a second and a second and a second a second and a second a 1 ☐ Yes 2 XNo Director Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 124 Ventnor Terrace Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Franklin Louk Sr. Patricia Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Louk mother 124 Ventnor Terrace, Dundalk, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Signature of Funeral Service Licensee withou 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the dise so or complications that caused the dist. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RAIN 24 HOURS disease or condition resulting in death) DEAT /Medical Due to (or as a consequence of) Examiner VENTRICULAR DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of Examiner and I-transit the death certificate be executed Urosepsis Due to (or as a consequence of) physician are the burial-t O. Box 68760 Physician/Medical signed by the attending plants as a be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown ۵. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death

Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 AUGUST 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUMFEH 4940 LAUDIA AD. 31. Date filed (Month, Day, Year) AUG 0 Registrar

Mark A. Lawson State of Maryland / Department of Health and Mental Hygiene 2008 25401 Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death 3. Time of Death Month Day July 30, 2008 **Medical Examiner** 1905 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funera! Months Hours Min. Director Country) 1 M 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Timor death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 2 No Yes 2 No 3 Yes. Give Yea Widowed Divorced Yes specify Specify 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Self Elementary/Secondary (0-12) College (1-4 or 5+) 721 is marked other than Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within and Mental Hygiene. 17 Father's Name (First Middle Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ohn a na 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. Apt 0111 If item 27 Department of Health 27 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial Cremation 3 Removal from State 1meL Other Specify 21. Signa e of Funeral Service Ilicense 22. Name and Address of Facility Approximate Interval Between Onset and **Physician** nter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. /Medical Death Intracerebral hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): cardiovascualr disease, metastatic tumor Atherosclerotic Sequentially list conditions if any, leading to immediate of mediastinum Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical g physician a PI line a-b, 27, perME, g883 9/16/08 X UNPENDED AMENDED requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Month Dav Year Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? ✓ Yes Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other-DOA this Inpatient 2 X ER/Outpatient 3 Nursing Home 5 Residence 6 1 Ves 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Pending Yes 2 No To the Funeral Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town State) (Specify) Homicid 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 31, 2008 NO owhen 0 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUL V (ZUUS Registra

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State of Maryland / Department of Health and Mental Hygiene 2000

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and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	Physic this ce	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho			y)
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Again (1) 10 0 140	within To the To the Comple	Mec		29d.	. Date signed (Month,	Day, Year)
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annual Human MD 22 South Greene Street	A RO	to MAN	21201
State 31. Date filled (Month, Day, Year) 32. Registrar's Signature Registrar			31. Date filled (Month, Day, Year) 32. Registrar's Signature		101	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legisle. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 2:30 ₽^M August Marion F. Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 717 Maiden Choice Lane, T - 23**Baltimore** Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year 27 9. Birthplace (State or Foreign Country)
New York 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 X F 80 102-22-0995 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 te marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Be Completed by Funeral Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 717 Maiden Choice Lane, T-23 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Stationery Buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Louis Levenson Sylvia Frolich 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Health Item 27 1010 Hilton Avenue, Catonsville, Maryland Charles R. Miller, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Depertment of Important: if eny injury or once. Metro Crematory, Inc. 8/6/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Leven H, Williams 22 MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD 21228 uu Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Causes Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, ettending physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached Division of Vital Records. P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ↑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes 211No 1 Yes 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e Medical 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			for State Registrar	State of iv	iai yiai i		artment of I rtificate of		aliu ivie		eg. No.	08	25404
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	Examin	ei	1331 Passage	Drive			0den	ton			Anne	Aru	nde1
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	/land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
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98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be natified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces ied 1 A Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No		gin? (Speci n, Puerto Ri	ify Yes or No- can, etc.)		k, White,	ean Indian, etc. ite
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<u>ة</u>	s 1 and f Health item 27 other to		20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Dat		20c. Location -		
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trae		21. Signature of Funeral Service		liams		Crematic 299 Fred	of Socility	iety	of Mary			21228
1	tificate be executed g physician and as the burial-transit	ledical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as or bue to (or as of b.	s a consequ	uence of):	er the mode of dy	ing, such as	cardiac or	respiratory arre	sst,		Approximate Interval Between Onset and Death Sun on His
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	atl		30. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)	(.	7	1 11	. 24 - /	771	054
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Registrar
DHMH 17 Rev 1/2001

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	amine		4a. Facility Name (If not ins Presbyteria	_				4b. City, Town, or Location of Death Towson					4c. County of Death Baltimore				
Fun Dire			5. Social Security Number 220–16–8786	6. 5	Sex 1 □ M 2 💢 F	7. Age (In yr 85	s. last birthday Yrs.) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I	irth Day, Year)	C	ountry	e (State of) ngtor	
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ary shou and M	nmat		19a. Informant's Name/Re	lationship	(Type. Print)		19b. Mail	ing Address	(Street	and Numb	er or Rura	al Route Num	ber, City or	Town, State,	Zip Co	ode)	
and 2 ealth n 27 i	ner tra		Mr. Douglas		r/ Son							on, Md					
Baltimore, Maryland 21215-0036 permit, Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: If them 27 is marked other than "natural", or	or of	П	20a. Method of Disposition 1 ☐ Burial 2 🕱 Crem		Removal from S	state	. Place of Disp cemetery, cre		_	i -		ate		ation - City or		, State	
Itim it. Pa Intmer Intant:	u dery		4 □ Donation 5 □ O	ther (Speci	(y) _	H3	illtop	O Nome or	d Addro	es of Facil	3-8-0			on, Md	•		
Derm Depa	any		21. Signature of Funeral S	ervice Lice	3			105	χ To Ο Yo	wson rk Ro	Fune 1. To	ral Ho wson,	me, Ir Md. 2	1204			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Certification of the condition of the cause of the cause of the cause of the cause of the cause (Final disease or condition)												ln	oproximate terval Betv nset and D	veen	
Physic	_	Î	Immediate Cause (Final disease or condition resulting in death)	_	, a			4 (< -	ھر ً	ai,	ect					5 4	
/Medi Exami	_		roodining ar doddin,	•	Due to (or as a conse	equence of):										
		je	Sequentially list conditions if any, leading to immediate Cause (Disease or injury		b. — Due to (or es e conse	equence of):										
acuted	transli	Examiner	that illidated events C.														
8760, cate be executed physician and	ourial-	Ě	resulting in death) Last Due to (or as a consequence of):														
68760, lificate be e g physician	sthe	edical			d												
Box 68 leath certific attending p	use a	Ž	IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, out				aran.				23	3d. Date of de	elivery		
O. Box he death cer the attendin	ed for	Physician/Me	in the past 12 months 1 ☐ Yes 2 🗷 No	1?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (specify)							Month Day Year				'ear	
P.C hat the	letach		9 ☐ Unknown Part II. Other significant c	onditions	contributing to de	eath but not re	esulting in the	ınderlyina c	ause niv	en in Part		23e. Did	tobacco us	e contribute t	to the	cause of de	eath?
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and	o pe pe	d by	Tarrii Guler Sigiinicunt G	ond tions	contributing to de	out out not n	Journal of the Control	andonymg o	addo giv				Yes 2	-		ly 4□U	
aw req	shou	Completed										24a. Wa		24b. Were a	utopsy	findings a	available
Re(The law ate has	bage 7	E O											opsy formed? 2 ⊭ No	prior to death? 1 ☐ Ye:		letion of ca	ause of
of Vital F Physician: The	ctor, I	Be	25. Was case referred to n examiner?	nedical							e of Death	Check only					
Of \ Physical	al dire		1 ☐ Yes 2 💢 No 27. Manner of Death		Hospital: 1 ☐ I	<u> </u>	ER/Outpatie			4,2,71				Other (Spe	ecify)		
Vision of Vital Attending Physician: or death.	ē l	ţi	1.⊠Natural 5 □	Pending investigatio	(Mont	h, Day Year)		" M	8c. Injur Worl 1 □	yaı k? Yes 2.⊑		28d. Describe	now injury	occurred			
/ISI Atten r deat ector:	by the	ifica	3 ☐ Suicide 6 ☐	Could not be	e 28e. Place	of Injury - At	home, farm, s	reet, factory						Number or Fi	Rural Fi	oute Numi	ber,
Div tal or rs afte	ed in	Certification: To	4 ☐ Homicide		buildii	ng, etc. <i>(Sp</i> e					- 50	City or Town, State)					
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A	completely fill	edical			hysician: To the miner: On the band mann)
To th within	com	Me	29b. Signature and title of	certifier		Atte	· 101.95 "	n.) 290	c. Licens	e number 370	16		29d. Date	signed (Mon	th, Da	y, Year) Zco	8
12	A		30. Name and address of p	person who		e of deeth (It	em 23a) (Type	Print)	is 51	L. Su	Je 4	105	Ja/+L	ا، ريد	39	214	۲ ت
	29b. Signature and title of certifier Attring my 29c. License number 29d. Date signed (Month, Day, Year) Angul + 7, 2008 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Kence h M. (Year, my 6701 iv. (houlds 5h.) Suche 4105 Sc./thom, who 2006 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 7 2008																
Re	gistra	ar	AUG 0 7	2008	Montes	0 15	Spran	Sand P									
DHMH 17 B	ov 1/20	01			_												

State of Maryland / Department of Health and Mental Hygiene 2008 1- State Registrar Amend Item 1 per dr., g882,08/07/08/bb f Death 1. Decedent's Name (First, Middle, Last) Lillian Marie 2. Date of Death 3. Time of Death **Physician** 0255 31 2008 /Medical 11/12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Canty bener lumbi 40 NO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Florida 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 80 1 □ M 2 □ 1928 June 1, Director 284**-**24-4080 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show 1 ☐Yes 2X No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4551 College Avenue 21043 USA ges 1 and 2 should be filed within 72 hours after death ont of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23 or other traumatic event, the "Modorl Evanding". Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No White Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis C. Powell Jessie Nevin ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman F. Powell, Brother 4551 College Avenue Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/02/08 21. Signature of Funeral Service Life hase Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ATheroscle 10 hc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation nours after death.

neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sighature and title of certifie who completed cause of death (Item 23a) (Type, Print) and address 10 21044 10 31. Date filed (Month, Day, Year) Registrar's Signature State 2008 AUG 0 Registrar

Physician PIUNTI CARMELA August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Bayview If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 KF Days Hours Min. 213-07-6710 Director ORIL 15,1915 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is fredical Exit altreminatic event, it is fredical Exit altreminatic event. Baltimore Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE <u>م</u> 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MILL OPERATER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAKMELA Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) dward 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 8-08 Redeemer 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
OSCIA N. ZANNING
635. Conkling 21. Signatu o Funeral Service Licensee Jr. 23a. Part 1. Enter the effea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failur. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death **Physician** HYPOXIA /Medical Due to (or as a consequence of): Examiner Heart Failure Congestive Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy

requires that the death certificate be executed P.O. Box 68760, cate has been signed by the attending I page 2 should be detached for use as Records, this certificate of Vital To the Hospital or Attending Physician: After thi funeral of Division death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

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Completed

Be

Certification: To

Medical

Aurtic Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death

Reg. No.

2008

3. Time of Death

9. Birthplace (State or Foreign

IUICA

Approximate Interval Between Onset and Death

Year

Dav

2 No 3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

Hours

MD

10d. Inside City Limits

1⊠Yes 2□No

11:12 AM

2. Date of Death

1∐Yes 2⊠No

Uroscpsis

9 Unknown

1. Decedent's Name (First, Middle, Last)

Baltimore, MD. 21224

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dr. Brian Silverman 4940

2008

Avenue. Lastern

32. Registrar's Signature

and manner stated.

31. Date filed (Month, Day, Year) State Registrar AUG U 7

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4b. City. Town. Pacility Name (If not institution, Examiner 8. Date of Birth (Month, Day, Year) (04/192 Birthplace (State or Foreign Country) **Funeral** Months Hours 04/04/1926 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County i show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, <u>the Medical Examiner must be notified at</u> Yes 2 No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 6711 PARK HEIGHTS AVENUE, #115 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No NAVY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. should be filed within 72 hours after 1 ☐ Never Married X Married 1 ☐ Yes 2 🔀 No 21215-0036 Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GROCERY OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) land Be Mental **POLLACK** ANNA GOODMAN ABRAHAM ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 21 5 and 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 6711 PARK HEIGHTS AVENUE, #115, BALTIMORE, MD Health tem 27 i BEVERLY POLLACK / WIFE 20a. Method of Disposition

Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place)
MIKRO KODESH - BETH 20c. Location - City or Town, State 6 Department of Important: If any injury or once, 4 Donation 5 Other (Specify) ISRAEL CONG. 08/06/2008 BALTIMORE, MD
22. Name and Address of Facility SOL LEVINSON & BROS., INC. BALTIMORE, MD 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimen Divease Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending physi I for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed l I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 2 No 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ Ho 24a. Was an Ø autopsy performed? res 2 No page certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 1 ☐ Yes 20No 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide t 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie D74053 Rugust 4,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Scot4 Les Rd B=1+ mD 21208 mo 32 pegistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Year Month Physician 3:30 M Michael Palmer August 2008 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Center N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 □ F 1-6-1958 MARYLAND Director 220-64-3239 50 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evention is used to expelled at N/A 1 TYPES 2 NO MD. BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 711 N. PAYSON ST. 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>-</u>8-DOLLAR GENERAL -0-SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance Pages 1 and 2 should be ment of Health and Ments ant: If item 27 is marked WOODROW WILLIAMS MARY L. PALMER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA JACKSON-PALMER(WIFE) 711 N. PAYSON ST. BALTIMORE, MARYLAND 21217 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 1 Cremation 3 ☐ Removal from State WOODLAWN CEMETERY 8-9-2008 BALTIMORE, MARYLAND 4 ☐ Donation / 5 ☐ Other (Specify) HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Ucensee JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition **Physician** Complications of Abdomina resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last THOUGH AN THOUGH AND THOUGHT A Due to (or as a consequence of) Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 M.Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 🔯 No death. investigation August of 2008 22:15 Motorcycle Collision 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Street Pennsylvania and Fremont St Baltimore, MD within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 18444 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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State Registrar 6701

32. Registrar's Signature

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CHMIRS

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 25411 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Edward Riley 2008 9:40 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 901 Johns Circle Anne Arundel Deale 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 5 1948 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 60 262-68-8203 Director Florida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at 10d. Inside City Limits Director MD Anne Arundel 1 ☐ Yes 2 No Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Johns Circle 20751 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 25 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile Layer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be int of Health and Menta t: If item 27 Is marked or other traumatic ev Riley Unk ဂ္ Unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Sheriden - friend 901 Johns Circle, Deale, MD permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8/6/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ② No 24a. Was an 2 No 1 □Yes 2 Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Tyes 2 No 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO57936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Bathmere, no 21201. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dav Year ROOKS MOOD HINIE OZ 08 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HUSPITER Park ashington Kem Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Months -031 **Director** North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Director 1 X Yes 2 □ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1139 Harvard Street, N.W. Funeral 20009 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Server Cafeteria 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Miles, Sr. ည Elsie Moody 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau Laura Rooks Clayton (Daughter) 419 Tabb Dr., Gaston, NC 27832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) Spring Cemetery: 8/2/08 Gaston, NC 21. Signature of Funeral Service License, 22. Name and Address of Facility Cofield Mortuary ennis P.O. Box 72, Weldon, NC 27890 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** she /Medical Due to (or as a consequence of): Examiner rtecomo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \((Specify) \) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 CARROLL AVE, STE340, TAKOMA PARK, MD 20912 MOBARHK KARIM, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 25413 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:40 P M Elizabeth August 3, 2008 Spann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6712 Crafton Lane Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖸 F Yrs. 247-90-3268 Director 29, 1949 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show item 27 is marked other then "natural", or items 23a or 28a-1 ehos other treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2X No Directo Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 6712 Crafton Lane U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Menta! Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Dept. of Defense Access Control Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jonas Drayton Mabel Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ernest Spann (Husband) 6712 Crafton La., Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o Union Baptist 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 Other (Specify) 8/8/2008 Church Cemetery Aiken, SC 21. Signar re of Funeral Service Licenses 22. Name and Address of Facility
Jackson-Brooks Funeral Home 126 Fairfield St. S.E. Aiken, anner Mu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Uno w.V disease or condition resulting in death) /Medical Due to (or as a consequent **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran Due to (or as a consequence of): physician certificate be Physician/Medical the attending p use as Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other signifigant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Records, been signated 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 24 of Vital 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 52 sidence 6 Other (Specify) 1 🗌 Yes 2 110 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 5 Pending death. 1 ☐ Yes 2 ☐ No spitel or Attendinours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I 29b. Signature at He of certifie 29d, Date signed (Month, Day, Year) Name and address of person completed cause of death (tem 23a) (Type, Print) 235 31. Date filed (Month, Day, Year) State 2008 AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) STEPNEY **Physician** LEDELL 4:15 AM AUGUST 1/100 4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 9. Birthplace 7. Age (In yrs. last birthday) (State or Foreign **Funeral** M 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Giv Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Be Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marriot 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 Is marked oth 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3618 (Oakment Ave or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State MARIANO 08-07-08 Important: I any Injury o Metro Crematory 22. Name and Address of Facility 21. Ciarrature of Juneral Service Licensee 4600 LUBERTY F Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RHODOCOCCUS SEPSIS Immediate Cause (Final disease or condition resulting in death) 21 DAYS **Physician** /Medical Due to (or as a consequence of): DISEASE RENAL Examiner END STAGE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): UNENDWA COAGULOPATHY be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.O. the 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ CIVIHOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed certificate 2 No 2 No 1 Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Yes 1. Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 2008 AUGUST Checque, co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONITE IHEAGWARA, 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2008

32 Registrar's Signature

		State of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygie	ne2008 25415		
		Registrar 1. Decedent's Name (First, Middle, Last)	unicate of Death	Reg. 2. Date of Death	No. 3. Time of Death		
Physicia		ROGER LEE SHAFFE	ER		Day Year		
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	AUG. U	4c. County of Death		
1		CARROLL HOSPICE DOVE HOUSE	WESTMINSTER		CARROLL		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213_46_3078 1 ▼ M 2□ F 5.0 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye			
Director		213-46-3078 **\bar{X} \bar{Z} \bar{F} \bar{S9} \bar{Yrs.} Usual Residence of Decedent		8/8/194	48 MARYLAND		
show show		10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits		
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ified within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural" or items 23a or 28a-f show ent, the Medical Exandrial must be rediffied at		10e. Street and Number	10f. Zip Code		Citizen of What Country?		
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permi Depa Impo any Ir					NSTER, MD 21157		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying such as cardiac	or respiratory arrest	Approximate Interval Between Oriset and Death		
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/Medical Examiner		Due to (or as a consequence of):					
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burial-transit		resulting in death) Last Due to (or as a consequence of):					
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The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery		
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he law e has ige 2 s	dmo			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?		
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ttend death. stor: / the fi	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stru	M 1 Yes 2 No	20f Location (Otto	A series of Post of March		
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Hospital or 24 hours afte Funeral Dir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only) 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place	, and due to the cau	se(s) and manner as stated.		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	and manner stated.					
P ≥ P ⊗	_	29b. Signature and title of certifier	29d License number	290	Date signed (Month, Day, Year)		
(x)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)				
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Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	restle)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 7:41 AM MI ovence /Medical Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner County Genera olumbia Howar HUSPIFA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Navs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F **Funeral** Year) Director and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.
n 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No **Funeral Director** moia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? erock Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education NY 124ears 4cars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lames Deolinda Willmore ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43249 20c. Location - City or Town, State VA 20176 a soul Devoler Cavell ashawn Berrien (20a. Method of Disposition
1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) larksville, 21. Signatur of Funeral Service Licensee Van Randalistry Libertu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** olon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed2 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) arner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 ittle SALVATERRA

Registrar DHMH 17 Rev 1/2001

State

ARMEN

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25417 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 22: 43M DNALD 2005 08 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HUSPITME If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months Days Hours 9-50-1287 **Director** Usual Residence of Decedent f show 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ es 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. f Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: ģ Pt Dir Ind: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+ Elementary/Secondary (0-12) ONC A ILL FIF Administration ONING 5/1947 61 M (SETT, CHARLES A YELLOW-O'NEIL 17. Father's Name (First, Middle, Last) ပ 07/05/1947 PADGETT, CH TEAM YELLO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Importa any inju once. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not ent if the mode of shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enforth ordering Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed NEUMODENIA burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by _4NG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2. No Division of Vital 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 Mo 1-Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD BALTIMORE. 601 21259 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07/25/08

1019459443 MR# 999994257

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Day 4 **Physician** 602 4119 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan 3,1946 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 213-46-2884 62 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f shov Examiner must be notified at Director 1X Yes 2 □ No Maryland n/a Baltimore 10e. Street and Number Charter 421 Carter Oak Avenue 10f. Zip-Code 10g. Citizen of What Country? 21212 U.S.A. Funeral , or Items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No If Yes, Give Year or Dates: 64-70 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. \$ White Specify: 3 Widowed 4 Divorced "naturai". Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) BGE Home Service Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth Alton Smith Sr. Kathleen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cheryl Smith (Wife) er Oak Avenue Baltimore, Maryland 21212 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marys Cemetery 8-8-08 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. of Funeral Service License 21. Signatu 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complication will traused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ≥ No certificate 2 II No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 Tyes 2 □ No Director: A d in by the fi 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) AUG 0 32. egistrar's Signatur

DHMH 17 Rev 1/2001

State

Registrar

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Louise Sexton /Medical 4a. Facility Name (If not institution, give street and number) Examiner itizens Harre de Grace Nursino Home If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F Director 21, 83 Feb. 1925 Maryland 214-26-6905 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland <u> Harford</u> Joppa 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21085 USA 202 Magnolia Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Manufacturing Assembly Line Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Oscar Timmons ဥ Martha (unk) Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Sexton 603 Charwood Ct., Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Furial 2 X Cremation from State Hilltop Service Corp. 8-7-08 Towson, Maryland 4 ☐ fonation 5 ☐ Other (\$pegity) 21. Signature of Fun Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Enter the dise not enter the mode of dying, such as cardiac or respiratory arrest, Imm liate Cause (Final Physician disease or condition resulting in death) /Medical equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician whodenic Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 Yes/ 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DQA 27. Manur of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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WHIM

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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			For State Registrar	State of Maryland		artment of H rtificate of L			ene 20 (08 25420	
	Physici /Medio		1. Decedent's Name (First, Middle, Last	H S	HUR			2. Date of Death	Pay o	ear 3. Time of Death	
	Examin Funeral Director	er	216-01-2292	Chesapeake		Linth	If Under 24 Hrs.	8. Date of Birth (Month, Day, 03/02/	Year) 9	Arundel Birthplace (State or Foreign Country) Maryland	
ie Maryland	ne Maryland 8a-f show ptified at	Director			Town or Lo	na				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	th with the 23a or 2 ast be no	al Dire	10e. Street and Number 8663 Cobscook	Harbour		10f. Zip Code 211	22	10	g. Citizen of Wha	S.A.	
36	urs after dea al", or items :xaminer mu	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Specin, Mexican, Puerto F	cify Yes or No- rican, etc.)		American Indian, White, etc. White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of workin	g 1	6b. Kind of Busin	,	
land 2	uld be filed Mental Hygi irked other itic event, t	To Be Co	17. Father's Name (First, Middle, Last) William James	Short	Ca	rpenter	18. Mother's Name Stepha	(First, Middle, M	laiden Surname)		
Mary	nd 2 sho ulth and I 27 is ma r trauma		19a. Informant's Name/Relationship (7) Catherine Short				and Number or Rural		•	ate, Zip Code) MD 21122	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Eneral Pervice Licens	Removal from State Mea	ace of Dispo emetery, crea down:	sition (Name of matory or other place idge Mem 2. Name and Addres	Pk 08/1	3/08 .Gonce	Baltimer	ore, MD al Home, PA	
	bhysician and hysician and the burial-transit	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.	ende of):	er the mode of dyin	g, such as cardiac o	respiratory arre	st,	Approximate Interval Between Onset and Death O AYS	
P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	death 3	⊒Ectopic pregnancy]Other (specify)	,		23d. Date o Monti		
	aw requires that s been signed s should be det	Completed by P	Part II. Other significant conditions co	entributing to death but not resu	. 4	g all bl	en in Part I	1 ☐ Ye	s 2 No 3	ute to the cause of death? Probably 4 Unknown ere autopsy findings available	
Vital Re	ician; The It sertificate ha ector, page 2	Be	25. Was case referred to medical examiner?	Hospital:		C+b	26. Place of Death		ned? dea	or to completion of cause of ath? Yes 2 No	
Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after cleath. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2.	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At ho building, etc. (Specify	28b. Time of Injury	f 28c. Injur World	□ DOA Outst. 4 □ Nursing Home 5 □ Residence 6 ♣ Other (Specify) 1 → 16 1 28d. Describe how injury occurred 28d. Injury at Work? 1 □ Yes 2 □ No				
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical Ce	29a. Certifier (Check only one) 1 CertifyIng Phy 2 Medical Exam	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat ion and/or ir	h occurred at the tir evestigation, in my o	me, date and place, a ppinion, death occurre	and due to the ca	ause(s) and mannate and place, an	ner as stated. Indicate to the cause(s)	
	To t withi To tl	Me	29b. Signature and title of confiden	J De Jent	ta w	29c. Licenso		8	Od. Date signed (Month, Day, Year) WT 04 3 008 MN 2401	
9	/		30. Name and address of person who of	LENY IN		PEFENSE	HIGHWI	Ay AN	NAPOLIS	M n 21401	
	Sta Regist	rar	31. Date filed (Month, Day, Year)	32. Prigistrar's Signat	ture	ne de					
DH	MH 17 Rev 1/2	001		-							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Ana Rubio MD.

31. Date filed (Month, Day, Year)

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29d. Date signed (Month, Day, Year)

July 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Day Year **Physician** lendon 2008 1350 M hom /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster
If Under 1 Year | If Under 24 Hrs. arrol Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 577-10-4146 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Director 1X Yes 2 No Westminst Maryland Carro 10e. Street and Number 10g. Citizen of What Country? USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. AUTOMOBILE 12 SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental JAMES CLENDON THOMPSON, SR. BARBARA WINTER Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra CAROLYN P. THOMPSON -WIFE 201 ST. MATTHEW CT., WESTMINSTER, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ALL COUNTY CREMATION 8/4/08 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. homes 254 E. MAIN ST., WESTMINSTER, 23a. Part1. Enter the disease, or c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cordiomyorally **Physician** longestuc Severe (year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed sician and burial-tran CERTIFICATION Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pi IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9∏Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sarcoidosis, Cancer of Prostate, HBP, Gerd, 1 Tyes 2 No 3 Probably 4 Whknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Lumbar Fractureh/ofall, COPD, CHF 24a. Was an page 2 autopsy performed 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 2 ER/Outpatient 3 DOA Certification: To the funeral 27. Manner of Death 28a. Date of Injury FOUNTED IN. Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1 Yes 2X No Multiple Falls 2 Accident 7-23-2008 4:00 A M 24 hours after deati e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 201 St. Matthew Ct. Westminister, Maryland filled in by 4 ☐ Homicide Home 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 2 MO 1)52035 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 CIMUCO 291 8 mue 31. Date filed (Month, Day, 32. Registrar's Signature Year) 03451 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Mundo 2008 /Medical 05 4a. Facility Mame (If not institution, give street and number) Examiner 4c. County of Death Ba WESSIX land Medical TIMOYE 5. Social Security Number If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country)
Philippines **Funeral** 8. Date of Birth (Month, Day, June 23, Year) 1941 1 X M 2 □ F 67 Director **216-75-6368** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 ☐ No MD Baltimore Parties Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a 20 E. Aylesbury Road 21093 Philippines Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 No Completed by 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Self Employeed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental 27 is marked c Marcelo Timpog Rosalina Panlaque 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Susan T. Cayanan / daughter 20 E. Aylesbury Road: Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) unk Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Himlayan Caviteno Cemetery Cavite City, Philippines 4 ☐ Donation 5. 21. Signature of Fun 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one case on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed 1 □ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death, To the Funeral Director: After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

SCOTT

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Month 1:55 PM M 3. Weintraub August Blass 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 6050 California Ave. Apt. 508 Rockville If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Jan 22, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2\ F Hours 1924 250-19-4519 84 Poland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6050 California Circle Apt. 508 20852 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bluma Goldwasser Noech Blass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1699 Southport Dr. Charleston, SC Maurice H. Weintraub - Son 20a. Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Brith Sholom Beth Israel 8/5/08 Charleston, SC 21. Signature of Funeral Service Licens J. Henry Stuhr, Inc. 232 Calhoun St., Charleston, SC 29401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a GASTROINTESTINAL STROMAI disease or condition resulting in death) 3425 Due to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy perforr 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

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To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

VICTOR M. PRIEGO 31. Date filed (Month, Day, Year. AUG 0 2008

29b. Signature and title of certifie

1 ☐ Yes 2 ☐ No

wo completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6420 ROCKIEDGE DR. BETTESOA, MD 20817

29c. License number

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **ESTELLE** Month Year MARIE WRIGHT 1:50 PM 2008 AUGUST 5, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GENESIS ELDERCARE TOWSON BALTIMORE 1 Year If Under 24 Hrs. If Under 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ M 90 Yrs Months Days Hours Min. 188-05-1155 4-25-1918 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE RASPEBURG 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 GREENHILL AVENUE 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS LAMM BROTHERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY DI NICOLA MARY ANTOINETTE (GATTA) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT WRIGHT/SON 5904 GREENHILL AVENUE BALTIMORE, 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 8-8-08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 21237 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final uncardi A disease or condition resulting in death) Due to was a consequence of) CONBU Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

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permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traun

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The law requires that the death certificate be executed

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Examiner and physician Physician/Medical attending properties for use as the : signed by t I be detach þ Completed has e 2 s certificate director. Be ۵ After the function Certification: To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. perforn 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

JUde 2848

State Registrar

29a. Certifier

29b. Signature

Medical

Glen

29d. Date signed (Month, Day, Year)

1 □Yes

2 🗆 No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month AUGUST 2008 01 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Jauson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 D F 217-34-4651 Usual Residence of Decedent **Director** 7.23.1936 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No WD Directo altimore 10e. Street and Number 10g. Citizen of What Country? McClego 4301 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No ρ Specify Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jerk Baltimore Co. Gov 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be rent of Health and Mental William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health an permit. Pages 1 and :
Department of Health
Important: If Item 27 I
any injury or other tra 1509 Chesaco Ave Basedale MD 21237
ce of Disposition (Name of Date 20c. Location - City or Town, State Wilton E. Belford. Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 8-11-208 Hereford, MD Lukes UMC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Voughon C. Greene Funeral Services 21. Signature of Funeral Service Licensee Vaughn C. Sheere 4905 York Pashirore

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Hemorrhage **Physician** /Medical Due to (or as a consequence of): **Examiner** Thoracic aortic aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? stenting Thoracic aneurysm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 XYes 2 No 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lerum D27740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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Robert A. Palermo 32. Registrar's Signature

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6701 N. Charles St., Towson, MD 21204 marke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Marilyn P^{M} Bronner Wilkes 2008 Weinberger 4:30 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔯 F Hours Min Year) Director New York 108_30 4113 Feb 26 1938 70 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be rediffed at Funeral Director 1 ☐ Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 1910 Pot Spring Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 [Yes 2] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 03 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 흅 of Health and Menta item 27 is marked ဂ Charles Frederick Bronner Jr Ruth Elizabeth Grant Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl A Weinberger/Son 4508 Hidden Hollow Drive Ellicott City MD 21043 more, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Soecify) 8/7/08 Dulaney Valley Mem Gardens Timonium 21. Signature of Futeral Selver icensed 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Michael A Flagle 21093 10 W Padonia Road Timonium MD 23a. Part 1. Enter the diseas 1, clications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): WILL Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the I 29b. Signature and title of certifier

State Registrar GEORGE BI 31. Date filed (Month, Day, Year)

16

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6701 N-Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEDON

MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 25428 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 31, **Physician** 2008 10:50 P M CONNIE MARIE WORKINGER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 327 North Earlton Road Harford Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ M Yrs. **Director** 213-68-2986 53 July 18, 1955 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important: If Item 27 is merked other then 'netural', or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2 ☐ No Directo Maryland | Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 327 North Earlton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ₩ No Specify: Š Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ഉ Nancy Irene Worrell Rev. Roy Lee Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 North Farlton Road, Havre de Grace, MD 21 ce of Disposition (Name of Date 20c. Location - City or Town, State Paul Workinger Jr./ Husband MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 8-4-08 Aberdeen, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Höspital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3☐ Probably 4☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perfor*m*ed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0666958 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danielle Gerry 2227 Old Emmortan Rd Suite 220 Belfr MD 21014 Suite 220 IG 0 32. Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner MOID Memoria 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye 7. Age (In y.s. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 💢 F 218-28-8175 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Exymiter must be notified at 10c. City, Town or Location 10a. State 1 (Ye) 2 (No Director 10g. Citizen of What Country? 10e Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2□N6 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: ò ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) dary (0-12) College (1-4or 5+) er's Name (First, Middle, Ma 18. Mot 17. Father's Name (First, Middle, Last) Be (ပ Informant's Name/Relationship (Type. Print tuckes 19b. Mailing Address (Street and Number or Rura Department of Health Important: If Item 27 any Injury or other to once. 2haror 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Pages 1 ₹ 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death. e Funeral Director: After this certificate has been signed by the aftending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 (Watural 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide completely filled 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier som avor, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620 200 East our a you onte

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:50 ₽ ^M ROBERT VINCENT ZABLOCKI AUGUST 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Director June 23, 1934 Pennsylvania 168-26-6067 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the resident Examine in until be mailtied at 10a. State 10b. County Director 1 ☐ Yes 2 ☐ No Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 1025 Erwin Drive 21085 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Sugar Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary (unk) Misenko Anthony William Zablocki ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryjane Zablocki / Wife 1025 Erwin Drive, Joppa, MD 21085 Baltimore, USIBURAL ☐ Cremation 20a. Method of sposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Demoval/from 5 ☐ Other (Specify) Gardens of Faith Cem. 8-7-08 Baltimore, Maryland 22. Name and Address of Facility
MCComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 e, or complications that caused the geat List only one cause on the line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. -dore En m mediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 ☐Yes 2 ☐ No 1 ☐ Yes Attending Physician: ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\to\) Nursing Home \(5 \) Residence \(6\)\(\times\)Other (Specify) \(\textbf{HOSPICE}\) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Modecal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Mopth, Day, Year) 29c. License number 29b. Signature le of contifier bods 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 AUG 0 Registrar

ZABLOCK

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician 11:20 SUSAN JANE ARNOLD 2008 Aug. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2058 Nelson Mill Road Jarrettsville Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Mpnth, Pay, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Yrs. 056-36-9439 9/1946 New York Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at 1 □Yes 2X No Jarrettsville Director Harford MD. 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ms 23a or 7 2058 Nelson Mill Road 21084 United States Funeral ıral", or Items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify. þ Specify: 3 Widowed 4 Divorced White 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Promotional College (1-4or 5+) than Elementary/Secondary (0-12) 12 Salesperson Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Herrick ೭ Russell Jane Wiggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard W. Arnold (Husband 2058 Nelson Mill Rd. Jarrettsville. MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 8/5/2008 Hampstead, Maryland 22. Name and Address of Facility 21. Signature of Fungral Service Licensee E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respire to Tour to of): **Physician** disease or condition resulting in death) /Medical Examiner Overian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 36 MUJ physician and s the burial-transit Primary Overime Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 **N**O 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred after death. I Director: After t 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier 116881 04 AUG 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Su 2. Registrar's Signature Lite 2000 Baltimer, MD tracklin 31. Date filed (Month, Day, AUG 0 7 2008 State Registrar

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		•	For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	partment of hertificate of	lealth and Death		giene ()	08	25432	
•			Decedent's Name (First, Middle)	, Last)					2. Date of Dea	ath		3. Time of Death	
Phys	sicia edica		Damon				Alston		July	19.	Year 2008	9:25 a M	
Exar			4a. Facility Name (If not institution	, give street and n		4b. City, Town, o	or Location of Dea		4c. County of Death				
			3010 Hickory		Dri	ve		ldorf		1	Char.		
Funer Direct			5. Social Security Number 579-68-7128	6. Sex 1X M 2 ☐ F		In yrs. last birthda 63 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1945	9. Birth Cou Wash	place (State or Foreign intry) ington DC	
and *		1	Usual Residence of Decedent 10a. State 10b. County		1	IOc. City. Town or	Location				Į.	10d. Inside City Limits	
death with the Maryland ms 23a or 28a-f show r must be notified at		ō	Maryland Char	rlas			Wal	ldorf			tion yes 2 □ No		
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3a or			3010 Hickory	Vallev	Dris	7 0	2	0601		T)	SA	Í	
deatl		Funerai	11. Marital Status	12. Was De	cedent Ev		I. Was Decedent of I	dispanic Origin? (5	Specify Yes or No-	14. R	ace - Ameri		
ite, INTAILY INTAILY ALK 13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental hygiene. Item 23 is marked other then "neturel", or frems 23a or 28a-f show other treumatic event, The Machael Examination multibe notified at		by Fu	1 Never Married 2 X Marri 3 Widowed 4 Divorced	ed 1 XYes	2 □ No	963-66	1 ☐ Yes 2 No		to rican, etc.)	1	lack, White, cify: Bla		
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al Hy		Be (17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle,	Maiden Suma	ame)		
should be nd Mental marked o		٥	Charles			Al	ston Sr.	Mary	M			Culbreath	
2 shc and and is my			19a. Informant's Name/Relationsh									p Code)20601	
1 and Health tem 27		- 1-	Karen Alston/ 20a. Method of Disposition	Wife			Hickory		y Dr.Wa	20c. Location			
Pages nent of H ant: If ite			1 XBurial 2 ☐ Cremation		n State		position (Name of ematory or other pla	1 .					
			*4 □ Donation 5 □ Other (Sp. 21. Signature of Operal Service I				Memoria 22. Name and Addre					Maryland	
permit. Departrimporte	once.		1 Thul	8	-							e PA and 20608	
		+	23a. Part1. Enter the disease, or	complications that	caused th	ne death. Do not e					агут	Approximate	
Physicia			shock, or heart failure. List	only one bause of	each line.	10	ric a	1 1				Interval Between Onset and Death	
/Medic			disease or condition resulting in death)	aDue to	o (or as a	consequence of):	1120		ver				
Examin	er		Sequentially list conditions,	h he	mt	His C	,						
D #		ner	if any, leading to immediate	or as a	consequence of):								
cate be executed physician and the burial-transit		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		consequence of):							
ate be ex hysician the burial	- 1		3 ,										
	:	dical		d									
death certific attending p	1	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or						23d. D	ate of deliv	rerv	
uires that the death cer signed by the attendin d be detached for use		Physician/M	in the past 12 months?	4□Preg	gnant at tin		☐ Ectopic pregnance ☐ Other (specify) _	у			Month Day Year		
trhe tache		hys	9 🗆 Unknown	9□ Unk	nown								
es tha gned		by P	Part II. Other significant conditio	11.11	death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to 1	the cause of death?	
w require been si should I			Chabetes	nellitus					1 🗆 Y	′es 2□No	3 □ Pro	bably 4. Unknown	
sicien: The law is certificate has be lirector, page 2 sh		Completed							24a. Was a autop perfor	an 24b	D. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of	
sten: artifica ctor, p		Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only or		10,103	20140	
hysic his ce		0	1 ☐ Yes 2 No	Hospital: 1	Inpatient	2 ER/Outpati	ent 3 DOA Ott	ner: 4 🗆 Nursing I	Home Chesid	lence 6 🗆 O	ther (Speci	fy)	
ding Phys		Ö	27. Manner of Deal 1 Natural 5 Pending	28a. Date (Mo.	of Injury onth, Day Y	/ear) 28b. Time Injury		ry at rk?	28d. Describe h	low injury occ	urred		
tend death for: /		cat	2 Accident investig	ot be				Yes 2 □No					
s after all Direct ad in by		Certification:	4 Homicide determi	ned 286. Plac build	ding, etc.	(Specify)	street, factory, office		City or Tow		nber or Hur	al Route Number,	
To the Hospitel or Attending Physicien: The law requires that the death certify thin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		edicai	29a. Certifier (Check only one) 1 Certifying 2 Medical E	exeminer: On the	ne best of i basis of ex nner state	xamination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occ	e, and due to the durred at the time, d	ause(s) and r	manner as s e, and due t	stated. to the cause(s)	
To the To the Comp		Ž	29b. Signature and title of certifier				29c. Licens	se number	4	29d. Date sign	ned (Month,	Day, Year)	
_			KM	(1) m			0 9	535	7	7-	21-	05	
DB53			30. Name and address of person v	XC.	27	29	e, Print) Lap	lofa	n	00	06	46.	
Regi	State istra	-	31. Date filed (Month, Day, Year) JUL, 2		Registrar's	s Signature	Sparke						

	1	For State Of Registrar	Cer	rtificate of L		R	eg. No. 2008	
Physicia	-	1. Decedent's Name (First, Middle, Last) Byron Edward Altemus				2. Date of Deal	Day 2008	3. Time of Death
/Medica Examine	40	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death	1 401	4c. County of Deat	th
· ·	10	CIVISTA MEDICAL CEN 5. Social Security Number 6. Sex 7.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	CHARU	
Funeral Director		213-48-8293	Age (In yrs. last birthday) 51 Yrs.	Months Days	Hours Min.	Month, Day June 25		thplace (State or Foreign ountry) sh. DC
land ow it		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
a-f sh	cto	MD Charles	Cobb I	sland				1 □ Yes 2□No
with the	ا ۵	10e. Street and Number 16320 Cobb Island Rd.		10f. Zip Code 2069	5	1	log. Citizen of What Co USA	ountry?
death	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
al", o	کر ا	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Date	□ No	1 ☐ Yes 2 ☐ No	Specify:			hite
72 hor "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of work	ing	16b. Kind of Business	/Industry
within jene. r than	dmo	Elementary/Secondary (0-12) College (1-4-	or 5+)	Carpenter	,		Constru	ction
be filed tal Hyg d other event,	Φ	17. Father's Name (<i>First, Middle, Last</i>) Albert Altemus					Maiden Surname)	
d Menid to marked matic	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street		ltemus	r, City or Town, State,	Zip Code)
alth an 27 is or traus		Roger Altemus/ Brother	2142	Briggs Ch	aney Rd.		Spring, Md	
ages 1 g nt of He t; If Item / or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta		osition (Name of matory or other place d-Echols (Date	20c. Location - City of Charlotte 1	
permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item Z7 is marked oth any Injury or other traumatic event once.		4 □ Donation 5 □ Other (Specify) 21. Sign for of Funeral Service Licensee		2. Name and Addre rehart-Ecl				nail, nu.
805 80		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	MO0945 2	11 St. Mar	ry's Ave	LaP1at	a Md 206	Approximate
Physician	5 7	shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	1.0	CE2				Interval Between Onset and Death
/Medical Examiner		resulting in death)	as a consequence of):		24012		_	
Lammer	e	Sequentially list conditions, it any, leading to immediate	as a consequence of).	CFF (121012			
cuted nd transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
tificate be executed g physician and as the burial-transit	al Ex	Due to (or	as a consequence of):					
tificate ug phys	Medical	0.						
eath cert attendin for use	Physician/M	in the post 12 months?		□Ectopic pregnancy	/		23d. Date of d	elivery Day Year
the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown						
Lires that signed to	by	Part II. Other significant conditions contributing to dea	th but not resulting in the t	underlying cause giv	en in Part I.	23e. Did to	obacco use contribute Yes 2 No 3 I	to the cause of death? Probably 4 □Unknown
w requ	Completed					24a. Was	an 24b. Were	autopsy findings available
The la ate has page 2	Comp					autor perfo 1∐ Yes	ormed? prior to death? 2178-No 1 □ Ye	
VILA Iclan: certific ector,	Be	25. Was case referred to medical examiner?		ont 3 DOA Oth	26. Place of Dea			
g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Meeth	Injury 28b. Time	of 28c. Inju	y at		dence 6 Other (Sp how injury occurred	pecify)
ending sath. or: Afte	atio	2 Accident investigation		M 1□	Yes 2 No			
al or Att	Certification:	determined 286. Place of	f injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (City or To	Street and Number or a wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) The Certifying Physician: To the base one one one one one one one one one on	is of examination and/or i	ath occurred at the ti investigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
^		1 KNall-	2		063383		JULY 2	2 2008
DB 15:1		30. Name and address of person who completed cause RAKFSH MAUK, MD 5	of death (Item 23a) (Type GARRETT A	Print)	BOX 107	O LA P	LATA, MD.	20646
Sta		31. Date filed (Month, Day, Year) 32.	gistrar's Signature	Societies				· · · · · ·

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Carolyn Sue Adams /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Wicomic Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Year) Month 1 □ M 2 X F 338-38-4789 61 April 16,1947 Illimis Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo **Funeral Director** Milford DF: Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5425 Big Stone Beach Road 19963 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced "natural" 16b. Kind of Business/Industry Item 27 is marked other than "nature other traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) home maker 8 own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental Η Be Carl Canull Elsie ဂ္ Sinnet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Tina M. Kobus 5425 Big Stone Beach Road, Milford, DE 19963 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If It any injury or o once. 1 N Burial 2 □ Cremation 3 □ Removal from State East New Market Cem. | 07/22/08 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 700 Locust Street, Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MRTASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-trail Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Dav for 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1/SYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2: autopsy After this certificate has 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Copatient 2 ER/Outpatient 3 DOA ဥ funeral (28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. I Division or Vital Records,

To the Hospital or Attendla within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

Musin 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

WAS

JUL 22

DHMH 17 Rev 1/2001

and manner stated.

COAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

20058410

29d. Date signed (Month, Day, Year)

8.0 Box 173) SACGIMUNY us 2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shawn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmoreput lumms If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2□ F Yrs. **Director** 220-25-6293 Usual Residence of Decedent 21 5/4/1987 MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, it is Intelled. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Funeral Director MD. Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2900 Tulip Way 21102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Be Completed by white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farmer farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick S. Burgan, Sr. Kelly (Flanagan) ပ 19a. Informant's Name/Relationship (Type. Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick S. Burgan, Sr. 2900 'Tulip Way, Manchester, Md. 21102

Be of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Immanuel Lutheran 7/26/2008 Manchester, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home 21074 934 S. Main St., Hampstead, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEVERE TRAUMATIC BRAIN DMMINENS /Medical Due to (or as a consequence of): Examiner TORCYCLE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year ☐Yes 2☐No P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 OKNO Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2020No 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 □ Matural Motercycle 23.00M 1 ☐ Yes 2 No 19/08 Crash investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) F-795 at Pe', STersTuwnforth determined 4 Homicide le's less own ord MA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 15 19076 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Baltimere Mp 2120. Jenniter Umms 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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Bendlin		State of Maryland / Department of Health and Mental Hyg 1- For State Certificate of Death	giene Reg. No. 2008 2543
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last) 2.	2. Date of Death Month Day Year 1632 brs
cal Exami	iner	Daulie Alli Bellotti	July 20, 2008 1632 hrs
No.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert Memorial Hospital Prince Frederick	4c. County of Death Calvert
Funeral			8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		Months Days Hours Min.	11/03/1978 Foreign Country) CA
		Usual Residence of Decedent	10d. Inside City Limits
v any		10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No
Maryland 28a-f show d at once.	ō	MD Charles Waldorf	10g, Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 20601	
th the			Scify Yes or No- 14. Race - American Indian, Black,
2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Ri	,
ter des			Specify: White
urs af tural amin	d by	Tor Dates:	ork done 16b. Kind of Business/Industry
72ho n"na al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	eu)
ithin 72 ene. er than Medical	am	12 Hiring Manager	Private
Hygical Market			(First, Middle, Maiden Surname)
ld be fi Aental I narked event,	Be	m	ural Route Number, City or Town, State, Zip Code)
and 2 shoul lealth and N tem 27 is rr traumatic	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 19b. Mailing Address (Street and Number or Ru 19a. Informant's Name/Relationship (Type, Print)	
and 2 lealth tem 2 traur	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Pages 1 ment of F tant: If i or other		1 Burial 2 X Cremation 3 Removal from State Riverdale Park 4 Donation 5 Other Specify: Aug	1 2008 Alexandria VA
permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21, Signature of Funeral Service Ligensee 22. Name and Address of Facility Bri	scoe-Tonic F.H.
permit. Departi Import			ton Rd Waldorf, MD20601
executed min and and laterals the reansit	I Examiner	or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
e be execut ysician and burial - tra	<u>2</u>	with the second with the secon	
ne death certificate the attending phy ned for use as the	hveician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown 9 Unknown 1 Other significant conditions 1 Contributing to death but not resulting in the underlying cause given in Part II.	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death?
that the	1 2	A A	1 Yes 2 No 3 Probably 4 Unknown
tal or Attending Physician: The law requires that the ra after death. The all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachled in by the funeral director, page 2 should be detach	nnloted	De Blace of Death (Check of	24a. Was an autopsy performed? 1 V Yes 2 No 1 Ves 2 No 2 Yes 2 No
certificate ector, page	[]		
hysician: this certifi il director,	6	200	ng Home 5 Residence 6 Other:
iding Phy h. : After the e funeral o	-	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe how injury occurred Subject drowned
sspital or Attending Ph hours after death. meral Director: After t y filled in by the funeral	ortificat	2 Accident Investigation Jul 20, 2008 1602 nrs 189 Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7200 Hallowing Point Road, Prince Frederick, MD
To the Hospi within 24 hor To the Funer completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To wi	3 3	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
)		Joeoha Gegus O.C.M.E.	July 21, 2008
		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	D 21201
	Stat	tate 31. Date filed (Month) Day, Year) 5 2008 Blower & Coast	

DHMH 17 Rev 1/2001 OCME 2006 OCME

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:10 PM Holward stian July_ 2008 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Berwyn Heights 6204 Quebec Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days 1**XX**M 2□ F Hours Director 212-54-2697 59 May 30, 1949 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Miccical Examinar mast be maritimal at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 XYes 2 No Prince George's Berwyn Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20740 6204 Quebec Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X∏Yes 2 ☐ No IfYes, Give Year or Dates: 169—171 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Louise Grusnick Charles W. Bastian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9107 6th Street Lanham, MD 20706 Susan Cannon/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/25/2008 Cheltenham, MD Veterans Cemetery 21. Signature Juneral Sovice License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or semplications that caused the shock, or heart failure. List only one cause on each line. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 105.4 MG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 □ Yes 2 • No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🗖 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

24 hours a To the within 2

29a. Certifier

(Check o

one)

29b. Signature

30. Name an

Medical

State Registrar

31. Date filed (Month, Day, Year) 2 2

Edelman

a dress of person who completed cause of death (Item 23a) (Type, Print)

Greene St, Baltimore, MD 22 South mi strar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ju**N**onth **Physician** 2008 08:15 PM Clinton Eugene Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 736 Ballast Way Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea 6/1/1920 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 **☑** M 2 ☐ F 310-18-3033 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mential Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 736 Ballast Wav 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces:
1 Types 2 No
If Yes, Give
Year or Dates: 1944-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Scientist NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Brown Ella Hutchason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai H. Jean Brown/ Wife 736 Ballast Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 7/23/08 Edgewater. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1e14514 /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 ☐Unknown 1 □ Yes Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▶ No 24a. Was an certificate has autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ∏Yes 2 ∏No 24 hours after death Funeral Director; 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 17. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner st within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ANNAPOLIS, MD 21401 31. Date filed (Month, Day, Year)

.IUL 2 3 2008 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05644 Peter Anthony Blake State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year Month Day July 23, 2008 1258 hrs Medical Examiner Peter Anthony Blake 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 10838 Oak Forest Drive 9. Birthplace (State or If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) New York Hours Min Months Day Director May 23, 1947 134-40-1507 1 X M 2 F 61 Yrs Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10b. County Yes 2 X No 28a-f show Maryland Washington Hagerstown with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number USA 21740 10838 Oak Forest Drive 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status or items. death v Armed Forces 1 Never Married 2 Married Yes Specify: White Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Yes 2 X No specify: 4 X Divorced Give Yea Widowed If item 27 is marked other than "natural", her traumatic event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Federal Government 12 Engineer 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Robert All Line..,

19a. Informant's Name/Relationship (Type, Print)

Abbaugh - Daughter Mary Be Blake Borcz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ timore, MD 19752 Mill Point Rd. Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State partment o 07/29/2008 | Smithsburg, Maryland Smithsburg Crematory Donation 5 Other Spec ö 22. Name and Address of Facility Osborne Funeral Home, P.A. Signature of Fun S.Conococheague St. Williamsport, MD 21795 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Intraoral Shotgun Wound Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been s , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? certificate ✓ Yes 2 1 🗸 Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifustely filled in by the funeral director, 1 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury Jul 23, 2008 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self Natural 0000 hrs Yes 2 V No Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 10838 Oak Forest Drive, Hagerstown, MD (Specify) Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the l within 2 To the l 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4-10

30. Name and address of person who completed cause of death (Item 23a)

2008

29b. Signature and title of certifier

31. Date filed (Mont) 19, Y2

Theodore M. King, Jr., MD.

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

State

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 24, 2008

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** GARY FIELD CARLSON JULY 27, 1500 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1 M 2 □ F Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 180-26-3402 Director 74 3/8/1934 PA Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location Od. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Expression must be notified at MD KENT 1 ☐ Yes 2 No Director CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7712 WATERVIEW LANE 21620 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEER PLASTICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARTHUR DELAYO CARLSON HELEN FIELD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA C. CARLSON/WIFE 7712 WATERVIEW LN, CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION: 7/28/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWN 130 SPEER RD. CHESTERTOWN, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been si , page 2 should t Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 1 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗹 Inpatient Director: After this of in by the funeral director မ 1∐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29d. Date signed (Morth, Day, Year) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

CHSSTERRA MO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05590 State of Maryland / Department of Health and Mental Hygiene Timmy Jerry Cornman 008 25442 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 21, 2008 1834 hrs ' Examiner Timmy Jerry Cornman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Hughesville NB Rt. 5 @ Gallant Green Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Country) Director 239 47 5561 1 X M 2 30 21 Ohio Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any Yes 2 XXNo s 23a or 28a-f show e notified at once. Maryland Charles Waldorf Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20602 United States 4853 Congressional Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1XX Never Married 2 Married Yes Yes 2 XX No specify: Specify: Divorced If Yes, Give Year "natural", Widowed White à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hos then to Fleath and Mental Hygiene trant: If item 27 is marked other than "na your other transmatic event, the Medical Example of the other transmatic event, the Medical Example of the other transmatic event, the Medical Example of the other transmatic event, the Medical Example of the other transmatic event, the Medical Example of the other transmatic event, the Medical Example of the other transmatic events. College (1-4 or 5+ Elementary/Secondary (0-12) 12 Manager Hospitality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Cornman, Jr. Pok Sun Chu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Cornman, (Father) Waldorf. MD 20602 4853 Congressional Court, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, July 26,2008 crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Waldorf, MD Trinity Memorial Gardens Other Specify: Donation 5 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old permit. Departn 21. Sign of re of Funeral Service Licenses Alexandria Ferry Road, Clinton, MD the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter hysician Between Onset and failure. List only one cause on each line. Death ledical a. Multiple Injuries Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit sician/Medical AMENDED UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✔ No 3 Probably 4 è Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 1 🗸 Yes 2 No ✓ Yes 2 page 26.Place of Death (Check only one) 25. Was case referred to medical director Be Other, examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes ٩ No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work 28b. Time of Injury After 27. Manner of Death Operator motorcycle vehicle collision Jui 21, 2008 1834 hrs 1 Natural 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director:
completely filled in by the fi Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) NB Rt. 5 @ Gallant Green Rd., Hughesville, Md determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 22, 2008 O.C.M.E. MU IND 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD nistrar's Signature 31. Date filed (Month Pay, Year) 5 State 2008 Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Lloyd Eugene Clinton, Jr. July 2008 12:47a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 29, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 212-30-7724 73 1934 Missouri Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 660 Bay Green Drive 21012 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1√2 Yes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney 5+ Law Ith and Mental Hygid 27 Is marked other traumatic event, ti 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd E. Clinton, Sr. Gladys Weakley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Clinton/Wife 660 Bay Green Drive Arnold, MD 21012 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 July 24, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 P2. Name and Address of Facility Barranco & Sons, P.A. 21 Signature of Fuperal Service Licensee Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 Ant1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** percardie /Medical Due to (or as a consequence of): Examiner neumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Pulmonay Hospital or Attending Physician: The law requires that the death certificate be executed evonic physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has the rector, page 2 s perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatient 1 ☐ Yes Ø No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, 24 hours a

within 24

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State

JeiD

(Check only

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Modical

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2008 Muriel Elizabeth Cotter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner**)1comi 8. Date of Birth (Month, Day, Year) Feb. 21, 1 1 Year Birthplace (State or Foreign Country) If Unde **Funeral** Days Months 1 □ M 2 🗓 F 82 1926 Massachusetts 011-20-4673 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1009 Riverhouse Drive, Apt. 6 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify White Š 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Logue Mary Connolly ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Ann Atwood/Daughter P. O. Box 312, Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State 7/20/2008 Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signatur of Fineral Service L 22. Name and Address of Facility. Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, Jensue MD 21802 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRTASTATIC **Physician** CARCINDANA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, trans, leading to finite data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician pe Physician/Medical as the t led by the attending I detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 □ Yes been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 10 1 ☐ Yes 1 Yes 2 → 10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No **⊁**PInpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t re Hospital or An.

thours after death.

al Director: After

by the fur (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUX 1733 SACISBURGIUM 21802 CHUMM WARY HOSPICA COASTAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 2

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2015 PM JUI: 20 2008 Emma Henry Clayton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Dorchester Cambridge Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🙀 F Director 219-36-5643 103 Oct 28,1904 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show XXYes 2 □ No Maryland Dorchester Cambridge Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 □ Yes 2√No Specify White δ 3 Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Je filed wit. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of Howard Wilson Ada Meredith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin M. Henry, Jr. 9035 Overhill Drive Ellicott City, Maryland 21042 Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Injury or 7/24/2008 Dorchester Mem Park Cambridge, Maryland Funeral Service Licenses 22. Name and Address of Facility 21. Signature Thomas Funeral Home, P.A my 700 Locust Street Cambridge. Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Vasculor prelio 10 min Physician resulting in death) /Medical Due to (or as a consequence of): Examiner 154m talvonuceal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner certificate be executed as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy jo Month 5 Other (specify) Yes 2 No the detached 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performe this certificate 2 XNo 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Tes 2 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Box 68760. P.O. I Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Certification:

Medical

5 Pending investigation

6 ☐ Could not be 3 ☐ Suicide 4 Homicide determined

29a. Certifier

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier Holaro

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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302 Collins pre Herrlock md 21643 Ackeln MA 31 Date filed (Month Day,

l 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Month **Physician** Pauline Elizabeth Dasher 0750 AM JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Centr If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 215-20-8922 83 March 23, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location the Maryland 10a State 10b. County "natural", or Items 23a or 28a-f show die A Examiner must be notified at 1 Tyes 2 No Director Maryland Frederick 3110 Will Mill Terrace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 3110 Will Mill Terrace 21770 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them any Injury or other traumary. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 seamstress sewing factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Harry McCurdy Bell, Sr. Sadie (NMN) Strubie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Beckner, nephew PO Box 1329, Pasadena, Maryland 21123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Crestlawn Memorial Gardens Marriottsville, Maryland 22. Name and Address of Facility Molesworth—Williams Funeral Home 21. Signature of Fi eral Servi 26401 Ridge Road, Damascus, Maryland the disease, or complications that caused the death. Do not enter the rnode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 P e sho, or h Immedia e Cause disease condit resulting in teath (Final Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Backrenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Hancrean head and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 210 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at its Medical 29a. Certifier (Check only one) Medical Exarniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Delmu Nayun MA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 3 2002

Nayak 22 S Greene St

32. Registrar's Signature

P21212

Baltimore MD 21201

JULY 20 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0709 M JAMES LEE DOLBY 111 22 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital at 10/1507 Laston Temorial Easton If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) SEPT.15,1966 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X**M 2□F 213-86-2481 41 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director EASTON MD TALBOT 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21601 USA 29424 CORBIN PARKWAY Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER/TECHNICIAN COMPUTER SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DELORES BOWIE ဂ္ JAMES L. DOLBY, JR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY R. DOLBY/WIFE 29424 CORBIN PARKWAY, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 7/25/2008 HURLOCK, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA M. (Strously Cf.SP. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Joseph Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence 1): **Physician** 2 yrs /Medical Examiner arranic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed Exami burial-trar Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy performe Yes 2 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred lospital or Attending P I hours after death. 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural
2 Accident (Month, Ďay Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) by 4 ☐ Homicide filled in within 24 hours at Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) è 90 D66202 TUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6+VA State

David C. Halveson
31. Date filed (Month, Day, Year)

MD 8221 TERL DR SUITE 302
32. Registrar's Signature

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2. Registrar's Signature

Registrar

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State Registrar DHMH 17 Rev 1/2001

BAHRAM 31. Date filed (Month, Day, Y

^{Year)} 5

32. P gistrar's Signature

MASHINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician Sal** 09/U M 0HN 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel 3705 Nile Road Davidsonville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/01/1937 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠**M 2□F Washington, D.C. 579-46-8511 71 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No "natural", or items 23a or 28a-f shedical Examiner must be notified Director Davidsonville Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21035 United States 3705 Nile Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □ Yes 2 🔼 If Yes, Give Year or Dates: 2 1 No 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paper Company Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be i Mental I Violet Davis John E. Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of the straight of the straigh 3705 Nile Road, Davidsonville, Maryland 21035 Dorothy C. Davis/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If iten
any injury or oth 3 ☐ Removal from State Kalas Crematory 07/21/2008 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fune at Service Lic 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ca SICIN NOT MELANDIM A WIDELY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2♥ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 2**K** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie M

Registrar

State

Year)

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Name and address of person

31. Date filed (Month, Day,

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completed cause of death (Item 23a) (Type, Print)

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NNAPOLIS MOZIYOI

08-05662 Delano Dunbar

amend lines 7 & 10e per fd aaco hith dept 08/01/08 dlw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 23, 2008 2114 hrs Medical Examiner Delano Dunbar 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Foreign Hours Min Months Davs Country) iberia 50 Director 58 31 371-68-7243 1X M 2 Jan Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b County 10a. State 1 XYes 2 No s 23a or 28a-f show a Anne Arundel Annapolis Maryland permit; Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1152 Med1 1152 Medgar Evers St. 21403 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc or items must be Armed Forces' Never Married 2 Married Yes 2 X No Specify: Black Yes 2 X No specify: Yes, Give Year Divorce 3 X Widowed 4 "natural", Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical than MD 21215-0036 Naval Academy 12th 2yrs Security Guard 18. Mother's Name (First, Middle, Maiden Surname) If item 27 is marked other 17. Father's Name (First, Middle, Last) Gertrude Mason Tilman Dunbar Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ MI 49022 Delaware Ave Benton Harbor, Agnes Peabody(Sister) 235 W. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, 1 X Burial 2 Cremation 3 Removal from State 7-31-08 Annapolis, Md Memoria1 Gardens tant: Donation 5 Other Specify: 0 A mame a Rederse Facilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 B. Been Moc883 Jan. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Death /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit 23a,27,perME, g882 8/22/08 TT Physician/Medical AMENDED physician the burial -X UNPENDED The law requires that the death certificate be Records F.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Dav 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte detached for u 1 Yes 2 No 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown <u>ج</u> Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' has 1 🗸 Yes 2 No ✓ Yes 2 No After this certificate 26.Place of Death (Check only one) e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certificielly filled in by the funeral director; I 25. Was case referred to medical Division of Vital Be Other₄ Residence 6 Nursing Home 5 Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME July 24, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0330 MARY NGAD 0 at /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/7/1920 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 F Director 138-12-2104 87 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 21XNo Director Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 1705 Midland Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Bookkeeper Insurance 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17 Father's Name (First Middle, Last) Be Arthur Biedermann Rose Veronica Hand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. D'Angelo/ Son 1705 Midland Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverside Meml. Park 7/26/08 Tequesta, FL 4 Donation 5 Other (Specify) 22. Name and Address of Facility George F. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy o Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1□ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number Signature and title of certifier Date signed (Month, Day, Year)

State

State 31. Date filed (Month, Day, Year Registrar

30. Name and address of person who

32. Legistrar's Signature

d cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month George Dale Dunlap \mathbf{P}^{M} /Medical July 20 2008 8:00 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months 1X M 2□ F 287-16-8110 Days Hours Director 84 July 30, 1923 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is "Modical Examination onte." 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Director Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7301 River Crescent Drive 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ■ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give WW II Ş 1 □Yes 2XXXIo Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify. Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Author Navigation Texts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Harrison Dunlap Alice Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Dunlap/wife 7301 River Crescent Drive Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1221 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 7/25/2008 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dire to for as a punsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Dav Year certificate has been signed by the a rector, page 2 should be detached it ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ∐Yes 1 ☐ Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

Registrar

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31. Date filed (Month, Day, Year)

JUL 2 3 2008 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F rtificate of I			iene eg.No. 2∩∩	0 251.5
		1. Decedent's Name (First, Mic	idle, Last)				2. Date of Deat		3. Time of Death
Physic /Medi		Kari Dyveke	Dragseth				Month July	Day Year 13, 2008	6:40 PIM
Exami		4a. Facility Name (If not institut		ner)	4b. City, Town, o	r Location of Death		4c. County of De	ath
		Montgomery G	eneral Hos	pital		Derwood		Montgo	merv
Funeral	Г	5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		9. Bi	irthplace (State or Foreign Country)
Director		None	1 □ M 2 🗷 F	85 Yrs.	Months Days	Hours Min.		1	lorway
р		Usual Residence of Decedent					12/0/	1-284	-
hours after death with the Maryland tural", or items 23a or 28a-f show all Examinar must be rotified at		10a. State 10b. Cour	ity	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mai	당	Norway None		Kristia	nsand				(Unk.) Yes 2 No
r 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
n wit	a D	Staiskleiva	12A A 4618		None			Norway	
. / 2 nours affer death with the Marylan "natural", or items 23a or 28a-f show ofical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede		Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Am	
or ite	Ŀ	1 Never Married 2 M	arried Armed Force	No No	If Yes, specify Cuba		nican, etc.)	Black, Wh	ite, etc.
E E	þ	3 ☐ Widowed 4 🖾 Divorc	ed If Yes, Give Year or Date		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
natur	Completed	15. Deced	ent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
iene. than "r	B	Elementary/Secondary (0-12	hest grade completed) College (1-4	life	kind of work done DO NOT use retired	during most of work d)	ang	Own Home	•
Hygiene.	E	12) College (1-4-	′	emaker				
atal Hygiene.	Be C	17. Father's Name (First, Midd	e, Last)			18. Mother's Nam	e (First, Middle, N	faiden Surname)	
ked ked	To B	Alfred Peder	Lino Troite			Efremi	ne Olsen		
f Health and Mental I ftem 27 is marked of other traumatic eve	-	19a. Informant's Name/Relatio	nship (Type, Print)	19b. Maili	na Address (Street			City or Town, State,	Zin Code)
trau		Lillan McCubb			-			, MD 2104	
ss 1 and 2 of Health item 27 i		20a. Method of Disposition	,					20c. Location - City o	
permit. Pages Department of the limportant: If ite any injury or of once.		1 🔀 Burial 2 □ Crematio				i		·	
tant jury		4 □ Donation 5 □ Other			th Family		26/08	Kristians	and, Norway
Deparation of the policy of th		21. Signature of Funeral Servi	ce Licensee	M00382 2	2. Name and Addre	ss of Facility eral & Cre	mation Se	rvices	
7 L = 4 O		Showy	Olmman	m				g, Maryland	1 20910-
		23a. Part 1. Entur the disease,	or complications that cau ist only one cause on eac	sed the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition	Dace						Onset and Death
Medical		resulting in death)	a. Due to (or	as a consequence of):					
kaminer			Fail	to The	ine				
	ē	Sequentially list conditions,	b. Due to or	as a consequence of):	noe				
physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	Severa	Osteon	aron				
al-tra	Xa	that initiated events resulting in death) Last	C. Due to (or	as a consequence of):	0 .				
siciar buri	<u>a</u>								
phys the	edical		d						
attending p for use as t		IF FEMALE:	23c. If yes, outco	me of pregnancy					
or us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 🗖 Fetal death 3 [Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
the a	sic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnar 9 ☐ Unknow		Other (specify)			Monai	Day Tou.
as been signed by the 2 should be detached	Physician/M						II		
igne be d	þ	Part II. Other significant cond	itions contributing to deat	h but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		to the cause of death?
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s be	Completed						24a. Was ar		autopsy findings available
te has age 2 s	Ē						autops perforn	ned? death?	
certificate ector, pag		25. Was case referred to media	and .	/					s 2 No
cert	Be	examiner?	Hoepital		ot all pos Oth	ar,	th (Check only one		
rthis raldii	ŀ.	1 Yes 2 No 27. Mann Death	1 Minp 28a. Date of	atient 2 ER/Outpatie	IL 3 L DOA	4 LI Nursing H		nce 6 Other (Sp	ecify)
After funera	<u>6</u>	1 atural 5 ☐ Pend	ling (Month,	Day, Year) 286. Time o	Worl	< ?	∠ou. Describe ho	w injury occurred	
death ctor: /	cat	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Coul	stigation			Yes 2□No			
after deatt Director: I in by the	Certification: To		rmined 286. Place of	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Str. City or Town	reet and Number or F , State)	Rural Route Number,
ırsa ral⊡ lledi	S								
within 24 hours To the Funeral completely filled	cal			est of my knowledge, deat s of examination and/or in					
winnin 24 nous aret dean. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	one)	and manner	stated.		pinon, death occu	at the time, th	are and place, and di	
2 - COT	Σ	29b. Signatore and title of certif	ier		29c. Licens		25	9d. Date signed (Mor	nth, Day, Year)
0		Hollan	V. MD		D65	1292		7/14/0	Z
~	1	30. Name od address of perso	on who completed cause of	of death (Item 23a) (Type,					_
		MARVIA VILL	ANUEVA		PRINCE P	HILPD	P. AINIE	EY MD	20832
Sta	te	31. Date filed (Month, Day, Yea		istrar's Signature	AF -	Y C D HOME T 4	- ULIVE	-1 1112	
J.C		1111 0	i onna l	10 11.	A A S				

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** /Medical CHARLES 80 0837 **EVANS** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 6, 1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min Yrs. 406-64-7445 Director 61 Κ̈́Υ Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov event, the Medical Examiner reset be notified at MD Allegany Director Cumberland 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 14222 Elton Drive SW Funeral 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 ☐ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" white Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) electrician CSX Railroad Health and Mental Hygie em 27 Is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Leo S. Evans Velva Conley Evans ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Evans wife 14222 Elton Drive SW Cumberland MD 21502 Department of Health Important: If item 27 any injury or other trong. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 8/6/2008 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Isean 10 000 Coronan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consection of Due to (or as a consequence of): Physician/Medical attending philosophers are at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Mellerless Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown end 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certification: To 29a, Certifier Medical 29b. Signature and title of certifier

2 Accident

4 Homicide

(Check only one)

3 Suicide

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625

State Registrar

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

VENUE

29c. License number

DOU 3328U

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Louise Ruch Ernst 2008 /Medical 4a. Facility Name (If not institution, give street and number)
Washington County Hospital 4b. City, Town, or Location of Death 4c. County of Death
Washington Examiner Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 – 22 – 1919 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours Min 219-66-2140 89 Director Fairview, MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Mutcal Experime must be neithed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18007 Sand Wedge Drive 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Was Deceuent _____ Armed Forces? 1 ☐ Yes 2 ☐ X 10 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White þ If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Preston Firey Emma Ruch ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Firey nephew 14702 Fairview Church Rd. Clear Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MBurial 2 Cremation 3 Removal from State 29, July Clear Spring, MD St.Paul Cemetery 4 Donation 5 Dother (Specify) 2008 21. Signature ²² Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc .O.BOX 310 Clear Spring, MD 21722 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 □Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Inpatient Inpatient 1 Yes Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 26

311-12

State Registrar

State 31. Date filed (Month, Day, Year) Strar JUL 2 9 2008

30. Name and address of person who complete

32. Registrar's Signature
ORIGINAL

cause of death (Item 23a) (Type, P(in)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 26,29d per dr/dvr 25457 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day A M 25 2008 0625 Alice Virginia Frazer Ju1y/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 15 Oakridge Court EIkton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 0CT 21, 19 Elkton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🗓 F 220-14-9177 82 Director 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15 Oakridge Court 21921 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "na any Injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Preston Stewart Clara Margaret Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice V. Frazer/Self 15 Oakridge Court, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 26, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2008 West Chester, PA 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** XIOYES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trai Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an page 2 s autopsy perform certificate 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other:
4 Nursing Home Residence 6 Detrier (Specify) Rocid 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the

29a. Certifier

29b. Signature and title of of tifig

State Registrar 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) **July 29,2008**

044716

Elkton, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 31. Date filed (Month; Day, Year)2008 STATE OF STATE OF

Physician
/Medical
Examiner

Funeral Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Forrest

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-tranattending pl page 2 s funeral director.

this

24 hours after death, e Funeral Director: A

filled in by

completely

To the

Division or Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year July CECIL RAYMOND FORREST 19 2008 9:55 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | MAR 27, 1924 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months 1**X**M 2□F 239-22-6147 84 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo TALBOT MD EASTON 10e. Street and Number 10g. Citizen of What Country? 3 VICTORIA COURT 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRONIC ENGINEER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ JOSEPH RAYMOND FORREST EFFIE HARE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSE ANN FORREST/WIFE 3 VICTORIA COURT, EASTON, MD 21601 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR 7/21/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 Snoull 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrorascular acciden weeks Due to (or as a consequence of) pertension Sequentially list conditions, if ny cause in the cause cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Meroscleros) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Wursing Home 5 Residence 6 Other (Specify) 200 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) 2

29b. Signature and title of certifier

(Check only



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHMANS

29d. Date signed (Month, Day, Year)

			1 - State of State of Registrar		ertificate of De	alth and Mental eath	Hygiene Reg. No.	2008	25459
	Physicia	an	1. Decedent's Name (First, Middle, Last)	-		2. Date of Month	of Death		3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and numb	l(NG	4b. City, Town, or Lo	ocation of Death	4c.	County of Death	7(-1)101
			432 Manor Road		Arnold		An	ne Arunde	el
1	Funeral Director		5. Social Security Number 213-09-8000 6. Sex 1 M 2 □ F 7	. Age (In yrs. last birthday 90 Yrs.		Hours Min. 8. Date (Mont	of Birth h, Day, Year) 22,19	9. Birthpla Countr 18 Penns	ace (State or Foreign ry) sylvania
	land Dw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			100	d. Inside City Limits
	a-fsho	ctor	MD Anne Arundel	Arnold					1 □Yes 2 🛣No
	with the	Director	10e. Street and Number 432 Manor Road		10f. Zip Code 21012		10g. Citiz	zen of What Countr	y?
	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the fledical Enaphrar must be rediffed at	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13		anic Origin? (Specify Yes of Mexican, Puerto Rican, etc.		14. Race - America Black, White, et	n Indian, c.
0036	ours after	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	es:		Specify:		Specify: Whit	
Maryland 21215-0036	thin 72 h ie. ian "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	ing most of working	16b. Kir	nd of Business/Indu	ustry
21	led wi Hygien her th nt, in s		8	Ka	ailroad Engi	Ineer 3. Mother's Name (First, M.		ilroad	
anc	be d d	To Be	17. Father's Name (First, Middle, Last) William Arthur Fleming		18	Catherine A			
ary	d 2 should thand Men thand Men 7 Is marked traumatic	Ĕ	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ling Address (Street and	d Number or Rural Route N			Code)
	D = C =		Susan Ann Wirth/ Daughter		Manor Road				
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	ate _	osition (Name of ematory or other place) Cemetery	July 22,	1	cation - City or Tow Limore, Ma	
Balt	permit. Departimport any inj once.		21. Signature of Foreral Service Licensee	Ë	22. Name and Address of Sarranco & S		everna	Park Fund	eral Home
ī			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not er				í	Approximate Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a.	Prostar	unur				Onset and Death
	Examiner			r as a consequence of):				(vear
	ed sit	iner	Sequentially list conditions, Due to for cause. Enter Underlying Cause (Disease or injury	as a consequence of):					
Ö,	ificate be executed g physician and as the burial-transit	Examiner	that initiated events c.	as a consequence of):					
68760,	ficate b physics the bu	edical	d						
XOA		an/IM	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outco	ome of pregnancy	☐ Ectopic pregnancy		2	23d. Date of deliver	,
у. О.	t the dea by the at ached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	nt at time of death 5	Other (specify)			Month E	Day Year
	w requires that the death cer been signed by the attendir should be detached for use	þ	Part II. Other significant conditions contributing to dear	th but not resulting in the	underlying cause given i			se contribute to the	e cause of death?
Hecords,	> 1 0	Completed					Was an autopsy		sy findings available pletion of cause of
	The sate h	Com					performed?	death?	2-EINo
VItal	Physician: r this certific ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Int	patient 2 ☐ ER/Outpatie	Othor	6. Place of Death (Check of		701 10 11	de Hulla
on ot	ding Phys After this funeral di	-10	27. Manner of Death Natural 5 Pending 28a. Date of (Month,		of 28c. Injury at Work?	4 Nursing Home 5 t 28d. Desc s 2 No	ribe how injury		Say HO I REPORT
DIVISION	To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building	f Injury - At home, farm, st ,, etc. <i>(Specify)</i>		28f. Locat	ion (Street and or Town, State)	d Number or Rural	Route Number,
_	Hospital 4 hours a 5 uneral [iely filled	0	29a. Certifier (Check only (Check only (Check only (Check Only (Ch	est of my knowledge, dea	ath occurred at the time,	date and place, and due t	o the cause(s)	and manner as sta	ated. the cause(s)
	o the l	Medical	one) and manne 29b. Signature and title of certifier		29c. License nu			e signed (Month, D	
	001)	* MI)	06	064379	7	-/21/200	8
	X		30. Name and address of person who completed cause	of death (Item 23a) (Type	Perint)	ld Sule jus	PA	MI)	31401
	Sta	te		gistrar's Signature	301921 -16	Jan	17114	tolin in	ertol
	Registra	ar	111! 2 3 2008	w to the	and a				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 Donna P. Fond /Medical 4b. City Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number KIVERSIDE If Under 1 If Under 24 Hrs. 9. Birthplace Country) Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 👿 F Yrs. Director Maryland 219-84-5522 May 31. 1961 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tien Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Aberdeen Director Harkord 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 3930 West Chapel Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Petersen Nancy Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond I. Ford, III (husband) 3930 W. Chapel Rd., Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. ne of uneral Service Licer 123 S. Washington St., Havre de Grace, Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy death? 1 ☐ Yes performed 25 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Hursing Home ို 5 ☐ Residence 6 ☐Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 ☐ Pending investigation 1 Tyes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certified eath (Item 23a) (Type, Print) 30. Name and address of person who complet d cause of 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG -7 2003

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Lewis B. Gorsuch 4:15p ^M 2008 July 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lorien Taneytown Nursing Home If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Director 219-14-9623 84 9/2/1923 MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3515 Ridge Rd. #2 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No If Yes, Give Year or Dates: 1945–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", Completed is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ward's maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Lewis Gorsuch Lilly Rash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3515 Ridge Rd. #2, Westminster, Md. 21157

e of Disposition (Name of Date 20c. Location - City or Town, State Department of Healt Important: If Item 2: any Injury or other once. Margaret Michael, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 7/23/2008 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 Stand S. Main St., Hampstead, Md. Semmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myopath disease or condition resulting in death) ardio /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ this nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier WIL 00058137 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) Stone 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician Estelle** Ε. Grant 07/21/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Prince George s

9. Birthplace (State or Foreign Country) Mitchellville If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 257 Hours Min. 212-04-5108 101 Director Feb.3,1907 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Events any injury or other traumatic event, the Modical Events and Ponce. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes X No Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3511 Eton Drive Jamaica Funeral 20772 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □YNo Completed by Specify: Specify: 3XWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNKNOWN) ပ္ Pertina (Hall) Ricketts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Bennett (Daughter) 3511 Eton Drive, Upper Marlboro, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July 23, 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Source Licensee 6633 Old Alexandria Ferry Rd. Clinton Approximate
Interval Between
Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. | cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes certificate has To the Hospital or Attending Physician: The 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature title of certifie

State Registrar 30. Name and address of person wh

31. Date filed (Month, Day, Year)

2

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5

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

32.

2008

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For Amend Item 26 State of Maryland / Departm		•
		1 - State WCHD/SH 8/4/08 per DR Certific 1. Decedent's Name (First, Middle, Last)	cate of Death	Reg. No. 2008 25463
Physicia /Medic		Albert Otto Gatz	Month July	Day Year 1:55 PM
Examin			City, Town, or Location of Death	4c. County of Death Washington
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If L	Under 1 Year If Under 24 Hrs. 8. Date of Birlinths Days Hours Min. (Month, Days	th 9. Birthplace (State or Foreign Country)
70		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Aug. 22	
a-f sho	ctor	Maryland Washington Boonsboro		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the	Director		of. Zip Code 21713	10g. Citizen of What Country?
r death	Funeral	11 Monitol Status 12 Was Decedent Ever in U.S. 13 Was I	Decedent of Hispanic Origin? (Specify Yes or No., specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the 11 dical Examinar must be notified a once.	þ	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	es 2 No Specify:	Black, White, etc. Specify: White
n 72 ho "natur	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of the DO Ni	s Usual Occupation of work done during most of working OT use retired)	16b. Kind of Business/Industry
ed with ygiene. er thar t, the	Com	12 3 Owner/C	Operator	Construction
d be file ental H ked oth c even	To Be	17. Father's Name (First, Middle, Last) ** Frederick Gatz	18. Mother's Name (First, Middle,	
shoul and M Is marl aumati	F		Anna dress (Street and Number or Rural Route Number	Kutzke er, City or Town, State, Zip Code)
1 and 2 Health Sm 27 ther tr				lph,NY 14772
Pages nent of nt: If its ry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory	(Name of yor other place) Cemetery 07-30-2008	20c. Location - City or Town, State
ermit, lepartin nporta ny Inju		21. Signature of Fuheral Service Vicensed 22. Nar	me and Address of Facility Osborne Fu	uneral Home,P.A.
<u> </u>				Williamsport, MD 21795
Physician			avma	Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):		,,,,,,
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Fater Underlying. Due to (or as a consequence of):		
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C		
0 0 0	dical	d		
eath certificate be execuratending physician and for use as the burial-tran	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ecto	ppic pregnancy	23d. Date of delivery
the dea y the att	Completed by Physician/Medi		er (specify)	Month Day Year
res that igned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underly Right Pelvis fracture Intra		obacco use contribute to the cause of death?
w requi	leted		-	Yes 2 No 3 Probably 4 Unknown
The lar	Somp		nary arterydisease 24a. Was autor performed 1 Tyes	an 24b. Were autopsy findings available prior to completion of cause of death? 2 1 Yes 2 No
slcian: certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only o	one)
g Phy ter this neral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. Describe h	dence 6 ☐ Other (Specify) how injury occurred
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al or A s after or I Direct	Certification: To	determined determined		Street and Number or Rural Route Number, wn, State)
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence (Check only one) Amedical Examiner: On the basis of examination and/or investige and manner stated.	urred at the time, date and place, and due to the	cause(s) and manner as stated
To the within To the comple	Mec	29b. Signature and little of servicer	29c. License number	29d. Date signed (Month, Day, Year)
孙	-) AGU	DOC56965	July 25, 7008
1 4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Land Completed Cause of death (Item 23a) (Type, Print)		mo 21746
Stat Registra		31. Date filed (Month, Day, Year) JUL 2 8 2008 32. Pgistrar's Signature	e ·	

DHMH 17 Rev 1/2001

		1- State of Mai		artment of Hea rtificate of De		lental Hygi Rei	ene g. No. 2008	25464
Physicia		1. Decedent's Name (First, Middle, Last) Dorothy Louise Green				2. Date of Death Month	Day Year 28 2008	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospita	1	4b. City, Town, or Loc	cation of Death	July .	4c. County of Deat	h
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign untry)
Director		162-22-4999	80 Tis.	cation		Nov.9, 19	927 Pen	nsylvania 10d. Inside City Limits
e Maryli 8a-f sho	Director	Maryland Washington		lagerstown				1 □ Yes 2 XXVo
h with th		10e. Street and Number 9702 Fernwood Lane		10f. Zip Code 2174	0	10	g. Citizen of What Co U	untry? S A
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Example Forces? 1 Never Married 2 Married 12. Was Decedent Example Forces? 1 Yes, Give	ver in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 ₩ S	nic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
in 72 hour n "natural fedical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done durir DO NOT use retired)	n ng most of work	ing 1	6b. Kind of Business/	White Industry
iled withi Hygiene. ther thar nt, the M		Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last))	Housewif	-	e (First, Middle, M	Hom	е
ould be f Mental i larked of	To Be	Grier Lehman Scriever				Elizabetl	,	
and 2 sh salth and 27 is rr er traurr		19a. Informant's Name/Relationship (Type. Print) Stanley F. Green - Husband		ng Address (Street and Fernwood L				Zip Code) 21740
ages 1 aent of He		20a. Method of Disposition 1XX urial 2 □ Cremation 3 □ Removal from State 4 □ Donatien, 5 □ Other (Specify)		osition (Name of matory or other place)	1		Oc. Location - City or	Town, State g, Pennsy I van is
permit. P Departm Importar any injur		21. Signature of Funeral Benyice Zicensee/	O's	Name and Address of	Facility Hom	e, P.A.		
		23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not ent	25 S. Conoc ter the mode of dying, s				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a	consequence of):	REPORT	TORY	PA (UKE	Oriset and Death
Examiner	ner	If any, leading to immediate Due to (or as a	consequence of):		LONA			
icate be executed physician and the burial-transit	Examine	that initiated events c.	TDL8 +(n consequence of):	1100				
tificate be ig physici as the bu	ledical	d						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at 0 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given ir	n Part I.	23e. Did toba	acco use contribute to	the cause of death?
siclan: The law rec certificate has bee irector, page 2 shou	Completed			120		24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
iclan: certific ector, j	Be	25. Was case referred to medical examiner?			. Place of Deat	h (Check only one	, , , , , , , , , , , , , , , , , , , ,	224110
Ing Phys After this uneral dir	on: To	1		f 28c. Injury at Work?	4 Nursing Ho	me 5 Resider 28d. Describe how	nce 6 Other (Spe v injury occurred	cify)
To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certification in the funeral director, the funeral director, to mpletely filled in by the funeral director, to	Certification:	2 Accident Investigation	ry - At home, farm, str (Specify)		2 🗆 No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
e Hospital 24 hours 5 Funeral etely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or in	th occurred at the time, nvestigation, in my opini	date and place, on, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier MGHAMMEO A2	10	29c. License nu			d. Date signed (Mont	
		30. Name and address of person who completed cause of de		D 66		0	7/29/08	
Sta Registr		or, bate filed (Monar, bay, rear)	r's Signature	ILIMM SF.	17 M 6 EK	SNOWL	110 4	170
negistr	वा	1111 2 9 2008	M A	TABLES !				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar			epartment of F Certificate of		F	Reg. No.	2008	25465
Physician /Medical	1	Decedent's Name (First, Middle, Las		RRIS			2. Date of Dea Month July	Day	Year 2008	3. Time of Death 4:25 P M
Examiner	4	a. Facility Name (If not institution, given Alice Byrd Tawes Social Security Number 6. S	Nursing Ho	Me (In yrs. last birth	Cr:	r Location of Death isfield If Under 24 Hrs.	8. Date of Birth		4c. County of Death Somerset	
Funeral Director			□M 2[X]F	-	rs. Months Days	Hours Min.	July 4, 1	, Year)	Mary	lace (State or Foreign try) land
or 28a-f show be notified at Director		0a. State 10b. County Maryland Somer 0e. Street and Number	set	10c. City, Town	Cr:	isfield		1000	10d. Inside City Li	
Examiner must by Funeral	n) ruicia	12 Cove Street 1. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		10f. Zip Code 13. Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2X No			14	USA 4. Race - Americ Black, White, of	an Indian,
ygiene. ner than "natur: t, the Medical E		15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of work d)	king		d of Business/Ind	,
n and Mental Hygie Is marked other raumatic event, <u>tt</u> To Be Co	מ מ	17. Father's Name (First, Middle, Last, Joseph B. Taylor			Co-Owner	18. Mother's Nam	e (First, Middle, le Whee]	Maiden S	Restaura Gurname)	ant
Department of Health and Ment Important: If Item 27 is marked any Injury or other traumatic e once.	2	19a. Informant's Name/Relationship (Audrey Hope Davis 20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of Specification) 21. Signature of Funeral Service Licentary Both Bra	(Daughter IRemoval from State y)	20b. Place of I cemetery Sunnyrick	Mailing Address (Street Cove Street Disposition (Name of crematory or other place Memorial Pa 22. Name and Addre 306 West Ma	ce) The control of t	ield, MI Date 25, 2008 C	218 20c. Loca Crist SON	317 ation - City or To ield, Ma IS FUNERA	wn, State aryland AL HOME
g physician and sas the burial-transit as th	Lyallille	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lysease or injury that initiated events resulting in death) Last	plications that caused one cause on each lin a. Due to (or as a b. Due to (or as a c.	the death. Do no	t enter the mode of dying SCVD,	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
for use a		FFEMALE: 23b. Was decedent pregnant in the past √2 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcome particles of the second	2 🗌 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23	3d. Date of delive Month	ery Day Year
be c	5	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he underlying cause giv	en in Part I.	23e. Did to			ne cause of death? ably 4 □Unknown
ate has bage 2		25. Was case referred to medical						sy med? 2 X No	prior to cor death?	psy findings available npletion of cause of 2 No
After this uneral di	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y 28b. Tir Year) Inj	ury Wor M 1□	4 Nursing Ho	ome 5 ☐ Resid 28d. Describe h	ence 6 ow injury		
hours after death neral Director: y y filled in by the f		4 ☐ Homicide determined 29a. Certifier 1 ★ Certifying Ph	building, etc	of my knowledge.	n, street, factory, office	me, date and place.	City or Tow	n, State)	Number or Rura	tated
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State Registrar	3	30. Name and address of person who Vijay Karumbun. 31. Date filed (Month, Day, Year) JUL 24	athan, M.D. 32. Registra	201 ir's Signature	ype, Print) Hall Highwa	y - Cris	field, M	ID 21	817	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph L Hardy Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LA PLATA MEDICAL ENIER 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Days Hours Min. 10/04/1927 Washington DC 216-22-2280 80 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Charles Brandywine 10g. Citizen of What Country? 10e. Street and Number 15100 Hardy Coates Place 20613 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No and 21215-0036 If Yes, Give Year or Dates: 1946-47 Specify. Specify: Black Completed by 3 ☐ Widowed 4 XDivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Melwood Crew Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Hardy Marv Coates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type. Print) Mar Joseph Hardy Jr./ Son 6561 Hill Mar Dr.Apt.201 Forestville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 7/28/08 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) extension Physician Minoners /Medical Due to (or as a consequence 1) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 this certificate or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide within 24 hours a 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waldorf Md HASAR POST Office Zatar 31. Date filed (Month, Day, Year) State Registrar

ARD

		1	For State Registrar	State of Mai	ryland / Depa <i>Cer</i>	tificate of L		eritai i iy	Reg. No.2	800	25467
	Physicia		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Christopher Will					July	22	2008	18:50 M
	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Westmi			4c. Co	ounty of Death Carro	11
. 165			506 Caldera Ct 5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th		place (State or Foreign ntry)
o.≠L	Funeral Director		403-49-4025	1 ₹ M 2 □ F	12 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cou	ntry) KY
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Mary I-f sh fled a	호	MD Carro	011	Westm	inster					1 ☐Yes 21 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	th wit		506 Caldera Ct			211	58			USA	
	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □Never Married 2□ Married	12. Was Decedent Ev Armed Forces? 1 \(\text{Yes} \) 22 No	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	. Race - Ameri Black, White	
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5	72 hor	sted	15. Decedent's l	Education rade completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation Jurina most of work	ina	16b. Kind	of Business/Ir	ndustry
V	ithin ne.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-}	DO NOT use retired udent)		Carro	oll Spr	ings School
7	filed within Hygiene. other than " ent, the Mes	8	17. Father's Name (First, Middle, Las		50	uacire	18. Mother's Name	e (First, Middle			
Z Z	ould be 1 Mental I arked of atic eve	To Be	Timothy Alan H				Heath	er Dawn	Cox	•	
Maryland	S D E E	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Numb	er, City or T	Town, State, Zi	ip Code)
	1 and 2 Health a em 27 Is		Timothy Hansen/Fa	ather		Caldera C		inster,		21158	
altimore,	m ∩ ⊾		20a. Method of Disposition 1 Darial 2 Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	e) 07/2	3/2008		ition - City or T	
	t. Pag tment tant:		4 □ Donation 5 □ Other (Spec	cify)		Cremation		1 7		mpstead	d, MD
g	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic		4	rices for 12 Washir	aton Road	d West	minst	er, MD	21157
	- 20		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplidations that caused t ly one cause on each line	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a Cecho	I Cabry	7.0					(Zyrs
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	7 0 30	0				
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68/60,	ficate be executed physician and sthe burial-transit	edical		d			· · ·	-			
	death certifii attending p	/Me	IF FEMALE:	23c. If yes, outcome p	of pregnancy				23	d. Date of deli	verv
. Box	that the death cer ed by the attendir detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐Pregnant at		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/			Month	Day Year
J.	t the by the	hys	9 Unknown	9□Unknown							
	es gu	δ	Part II. Other significant conditions	s contributing to death bu	it not resulting in the u	ınderlying cause giv	en in Part I.		tobacco use		the cause of death?
Ö	w requir been si should	eted									
ě	he law has b ge 2 s	Completed							opsy ormed?	prior to death?	topsy findings available completion of cause of
<u>a</u>	an: T tificate or, pa		25. Was case referred to medical				26. Place of Dea	1 Yes	2 No	1 LI Yes	2□ No
5	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	nt 3 DOA Oth				□Other (Spec	cify)
0	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		of 28c. Injus Wor	y at k?	28d. Describe	how injury	occurred	
Sio	tendli eath. tor: A the fu	catic	2 Accident investigat 3 Suicide 6 Could not	ho			Yes 2 □ No				(0
Division or Vital Records,	lor At after d Direct	Certification:	4 ☐ Homicide determine		ry - At home, farm, st c. (Specify)	reet, ractory, onice			(Street and own, State)	Number or HL	ıral Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of	examination and/or in						
	To the I within 24 To the I complete	Medical	one) 29b. Signature and tiple of certifier	and manner sta	ited.	29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
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	3		30. Name and address of person w		eath (Item 23a) (Type			1	1	√- - -	
			1070	30 Washing		ks Medic	ed Cont	v W	stul	note.	WW 21177
		ate rar	31. Date filed (Month, Day, Year) JUL 2 5	2008 32. Heristra	ar's Signature	1 ,					

			For State Registrar	State of	Maryland / De	partmen <i>ertificat</i>			and M		ene g. No. 2	ากล	251.68
			Decedent's Name (First, Middle, La	ast)						2. Date of Death	1		3. Time of Death
	Physici		Lola Appolonia	Hadlic	ς					Month	Day 200	Year 18	4:25 p ^M
-	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and numb	per)	4b. City,	Town, or	Location of	of Death		4c. County		
and I			3601 Tarkington	Lane		Sil	ver	Sprin	ıg		Monto	gomei	су
	Funeral			Sex 7. 1 □ M 2 X F	. Age (In yrs. last birthd	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)	Co	hplace (State or Foreign untry)
	Director		4/5-28-/115	TO W 2-E 1	76 Yrs					Aug. 22,	1931	Mi	innesota
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					<u>_</u>		10d. Inside City Limits
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	the 1	Director	Maryland Mont 10e. Street and Number	gomery	SIIVE	10f. Zip				10	g. Citizen of	What Co	untry?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, "Ite Modical Exprirence, ust by nutified at or other traumatic event, "Ite Modical Exprirence," ust by nutified at	<u>~</u>	3601 Tarkingto	n Lane			209	06			USA		
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Maryland	12 st th and 7 is n traur		19a. Informant's Name/Relationship							al Route Number,			21/01
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آور	Pages nent of ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 [ate 20b. Place of Di			-		July 24	.oo. Loodaton	Oity Oi	iowii, otato
Baltimore,	it. Pg rtme rtant njury		4 □ Donation 5 □ Other (Spec		Gate	f Heav		<u>'</u>		2008	Silve	er Sp	oring, Maryla
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		-	23a. Part 1. Enter the disease, or con	nnlig tions that say	used the death. Do not							Sprin	ng, MD 2090
			shock, or heart failure. List only	ne cause on eac	ch line.	enter the mot	ie or dylli	iy, suci as	cardiac	or respiratory arre			Approximate Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)		n Cardiac D	eath							
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		-	Sequentially list conditions, if any, leading to immediate	b. Conge	stive Heart ras a consequence of):	Failu	re					-	5 years
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	execu and al-tra	xal	that initiated events resulting in death) Last	c. <u>Hyper</u> Due to (or	tension ras a consequence of):								20 years
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687	ificate g phy is the	edic		u									
Вох	eath certific attending p for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy						23d. Da	ate of del	ivery
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ta	an: T tificat or, pa	ပိ	25. Was case referred to medical	Ţ				OF Disease	a of Dooth	1 ☐ Yes 2 (Check only one		1∐Yes	2 🗆 No
5	Physician: r this certifica ral director, p	00	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	patient 2 ER/Outpa	tient 3 🗆 DC	Othe	or:		me 5 X Reside	·	har /Caa	oif d
Division of Vital	g Phy er thi eral c	Certification: To	27. Manner of Death	28a. Date of (Month)			28c. Injur			28d. Describe ho			City)
on	Attending or death. ector: After by the fune	Ę.	M Natural 5 Pending 2 Accident investigation		, <i>Day, Year)</i> Inju	M		<br Yes 2□	No				
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Ö	al or s afte I Dire	ert	4 ☐ Homicide determined	bullaing	, etc. (Specity)					City or Town	, State)		
	spita hours mera y fille		29a. Certifier 1 Certifying F	hysician: To the b	est of my knowledge, d	eath occurred	at the tir	me, date a	nd place,	and due to the ca	ause(s) and n	nanner as	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exa	miner: On the bas and manne	sis of examination and/or stated.	r investigation	, in my o	pinion, dea	ath occurr	ed at the time, da	ate and place	, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1,		290	c. License	e number		29	d. Date signe		
			1 LABINA	un	-mn			D050	0612		July	22,	2008
	+		30. Name and address of person who	completed cause	of death (Item 23a) (Ty	pe, Print)							
			Samuel G. Maller		3305 N. Lei		orld	Blvd	1., S	ilver Sp	oring,	MD 2	20906
	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Signature	Lank.							

DHMH 17 Rev 1/2001

			Please T	ype or Print i					-			
		-	For State	State of Mary	and i				Mental Hy	/gier	ne	
_			State Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate of	Death	2. Date of D	Reg. N	<u>6.200</u> 8	3 25469
Phys	sicia	ın	do : 1	h. H					Month		Day Year	3. Time of Death
/Me Exa	edic		4a. Facility Name (If not institution, give s	street and number)	on		4b. City. Town, o	or Location of Deat		14	Ic. County of Dea	1,10p "
LAG		ΨI	Charlestown Care (ŕ			Catonsv				Baltimor	
Fune	ral		Social Security Number 6. Sex	7. Age (In	yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth	9. Bir	rthplace (State or Foreign ountry)
Direct	tor	-	577-20-9958 Usual Residence of Decedent	9	2	Yrs.			Oct. 1			hington, DC
/land ow			10a. State 10b. County	100	. City, T	own or Lo	cation					10d. Inside City Limits
Many a-f sh		tor	Maryland Baltimore	e C	aton	svill	Le					1 X Yes 2 □ No
th the or 28% e not		Directo	10e. Street and Number	-			10f. Zip Code			10g. (Citizen of What C	ountry?
ath wi 23a ust b		ra	7119 Maiden Choice				21228			US		
er deg items		Funeral	The trial clarate	12. Was Decedent Ever Armed Forces?	in U.S.	13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (5 an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Whi	
hours after articles are all the samile and the samile are articles are are articles are articles are articles are articles are article		by F	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			I∐Yes 2∭XNo	Specify:			Specify:	hite
at yidilid AIAID-OUGO should be filed within 72 hours after death with the Maryland nd Mental Hyglene. ** marked other than "natural"; or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at			15. Decedent's Edu	cation	1	6a. Deced	lent's Usual Occu	pation		16b.	Kind of Business	
Lithin 7 e. an "n		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	kind of work done DO NOT use retire	during most of wo	rking			
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d be file ontal H ed oth		Be	17. Father's Name (First, Middle, Last)					18. Mother's Na			,	
hould d Mel		2	Harry Hudson Hiett 19a. Informant's Name/Relationship (Ty.)			10h Mailir	an Address (Street	Effie I and Number or R	ouise S			Zin Codo)
Man 2 SI Ith and 27 is r			Judith A. Hatton/	Daughter -:			-	ood Turn				Zip Code)
ore, Mc		Ì	20a. Method of Disposition	2	0b. Plac		sition (Name of natory or other pla		Date	1	Location - City o	r Town, State
Page Page Int: If			1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemovar nom State	M	aryla	and Cemetery	1 7 10	23/2008	Ch	eltenham	. MD
DallIIIIOTE, MISTYISIIIG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Inlux or other traumatic event, the Medical Examiner must be notified at	once.	1	21. Signature of Funeral Service License	ee	vere	22	2. Name and Address	ess of Facility Ro	bert E.	Ev	ans Fune	ral Home
0 835 8	Б		1 fotgin	5		16	5000 Anna	apolis Ro	ad Bowi	e,]		
	n		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the ne cause on each line.	death. I	Do not ent	er the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicia /Medic			Immediate Cause (Final disease or condition resulting in death)	Prue								Onset and Death
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lospit hour uner			29a. Certifier 1 Certifying Physical Exami	sician: To the best of m	y knowle	edge, deat	h occurred at the t	time, date and place	e, and due to th	e cause	e(s) and manner a	as stated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has someleely filled in by the funeral director, case 2.8		Medical	one)	and manner stated					direct at the time			
5 × 5 2	3	_	29b. Signature and title of certifier	0				se number		29d.	Date signed (Mor	ntn, Day, Year)
n	nQ	N	30. Name and address of person who co	wer IV	nn	20) (T		377			+1141	8
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Reg	jistr	ar	JUL 2 3 200	32 legistrar's	B	1	and .					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Lester Edward HAMBY.Sr. July2008 7:15DM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Reeders Memorial Home Washington Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 X M 2 □ F 83 217-18-8470 6, 1924 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Marvland Washington Hagerstown 1 ☐ Yes 2x No 'natural", or items 23a or 28a-f shi Idal Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14811 Cearfoss Pike 21740 U.S.A. Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 May Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 X No 2 3 X Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 16a Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 21/21 College (1-4or 5+) Elementary/Secondary (0-12) correctional officer state gov't 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last, 2 should be fill and Mental H Be Lester C. Hamby Ethel G. Edwards ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paula Jordan - daughter 14752 Cearfoss Pike, Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemelery crematory or other place)
Broadfording Church
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 29 2008 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Mal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 2 week INDMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARL. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine SIANS POST GASTRIC TUBE death certificate be executed attending physician and for use as the burial-transit 45 PHAGIA Due to (or as a consequence of): P.O. Box 68760, Yums Physician/Medical MULTIPLE as b IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 2 No Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 No 1 Tes P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Matural 2 ☐ Accident Injury 5 Pendina To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14656 Cedu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00H5+1 DrGhAZALA Qadir 20311 Lappans Rd. Boonsboro, Md 21713/301-432-8470 31. Date filed (Month, Day, Year) strar's Signature State JUL 2 8 2008 Registrar

DHMH 17 Rev 1/2001

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		For		State of Ma	arylan					Mental H	ygiene	2009	8 25471
	_	State Registrar					Certifica	te of	Death	T	Reg. No.	2000	
Physicia	an	1. Decedent's Name		,						2. Date of D Month	Day	y Year	3. Time of Death
/Medic	al	Ruth	110001		Hopk	ıns	45.0%	T	- Leasting of Dan	July	31	2008	
Examin	er		irnotinstitution, giv ions Heal	th Care			4b. City		Location of Dea Kesville		4C.	County of Deat	
Funeral		5. Social Security N			e (In yrs.	last birth		r 1 Year	If Under 24 Hrs	8. Date of E	Birth (roll thplace (State or Foreign
Director		215-20-88	365 1	I□M 2 X F	82	Υ	rs. Months	Days	Hours Min	Apr.	21, ^{rear})	926 Mar	y land
pu		Usual Residence of 10a. State	f Decedent 10b. County		10c Cit	y Town	or Location						10d. Inside City Limits
Aaryla f sho	-			wa 1 1	100. 01	y, 10wii		114-					1 ☑ Yes 2 ☐ No
with the Maryland or 28a-f show the notified at	Director	Maryland 10e. Street and Nur		roll				p Code	minster		10g. Cit	izen of What Co	ountry?
3a or		62 Sy	ycamore S	treet					21157			U.S	.A.
death w	Funeral	11. Marital Status	,	12. Was Decedent Armed Forces?	Ever in U.	S.	13. Was Dece	edent of h	lispanic Origin? (an, Mexican, Pue	Specify Yes or N	10-	14. Race - Ame Black, Whit	
or ite			ried 2 Married	1 □Yes 2XI	No		1 ☐ Yes		Specify:	to rucan, ctc.)		Specify:	
be filed within 72 hours after death with the Maryland tital Hygiene. In the Hygiene, of other than "natural", or items 23a or 28a-f show event, the Mydical Exercited rests the notified at	ed by	3 Widowed		Year or Dates:		160 [Dagadanta Ha	ual Oasur	ation		16h K		Black
in 72 "nat	olete		15. Decedent's Ed	ade completed)		1 (Decedent's Usu Give kind of wi life. DO NOT u	ork done	during most of wo	orking	IDD. K	ind of Business	rindustry
withi	Completed	Elementary/Seco	9 (0-12)	College (1-4or 5	5+)		dom	esti	c		pr	ivate h	nomes
al Hyg othe vent,	BeC	17. Father's Name	(First, Middle, Last,	")		,			18. Mother's Na	me (First, Midd	le, Maiden	Surname)	
Ment Ment arked	ဥ	Carro	oll Hopki	ns, Sr.		,			Maggie	Ann Rol	oinso	n	
2 sho n and ls ma raum			lame/Relationship (and Number or F		-		
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", any Injury or other traumatic event, the Medical Ex- once.			☐ Cremation 3 ☐	Removal from State			Disposition (Na ; crematory or						
artme artme ortani Injury			5 ☐ Other (Specification of the state of th		La	ke V	iew Men	n. Pa	ark 8/6	/2008	Syk	<u>esville</u>	, MD
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Physion this of ral direction		1 ☐ Yes 2 ☑				_	patient 3 🗆 🗆	JOA		_		6 ☐ Other (Sp	ecify)
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ne Hospital or Attendin n 24 hours after death. ne Funeral Director: Af pletely filled in by the fur	edical (29a. Certifier (Check only		hysician: To the best									
To the h within 2, To the F complet	Medi	one) 29b. Signature and	d title of certifier	and manner st	tated.		2	9c. Licens	se number		29d. Da	ate,signed (Mon	ith. Dav. Year)
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		30. Name and add	iress of person who	completed cause of	death (Iter	m 23a) (Type, Print)				3	110	
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Sta		31. bate filed (<i>Mor</i>	nth, Day, Year) JG - 7 200	32. Regist	rar's Signa	ature	make B						•
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 3, Day 2008 Year 1:45 PM M **Physician** Mary Louise Johnston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Citizens Care & Rehabilitation Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Hours 1 □ M 2 □ F 81 Feb. 1927 216-22-9394 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be prolitical 1 Yes 2 No Frederick Frederick Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with U.S.A. 21702 1900 Rosemont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No þ Specify White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Market is the Market in the Market is any injury or other traumatic event, the Market is any injury or other traumatic event, the Market is any injury or other traumatic event, the Market is and injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Hardware Store Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Mullican Lloyd Zimmerman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
116 South Jefferson Street, Frederick, MD 21701 19a. Informant's Name/Relationship (Type. Print) Cheryl Mullican, cousin Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug. 7, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each he. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (e) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed physician and s the burial-trans Box 687605 Due to (or as a consequence of): Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. I ed by the a detached f 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 st autopsy performed? 1 □ Yes 1 ☐ Yes 2 ☐ No of Vital spital or Attending Physician: Thours after death.

neral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2/No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Wath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital within 24 hours a 1 Mifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my activities to the cause (s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number August 4, 2008 30. Name and address of 32 Registrar's Signature State 2008 0 Registrar

DHMH 17 Rev 1/2001

2008 25473 State of Maryland / Department of Health and Mental Hygiene Darrick Jackson 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 22, 2008 1251 hrs Medical Examiner Darrick Jackson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cheverly Prince George's Prince Georges County Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Days 57 Director 5/30/51 Country) NY, NY 091-40-5902 1XXM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Capital Height's 1 X Yes 2 No P.G. "natural", or items 23a or 28a-f show Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 USA 82 Daimler Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status marked other than "natural", or items c event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Yes Black Divorced If Yes, Give Year Yes 2 X No specify: δ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) permit: Pages 1 and 2 should be filed within 72 hou.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturingury or other tranmatic event. "h. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pepco Meter Services 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Pugh Eugene Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 82 Daimler Dr., Capital Height's MD 20743 Sarah Jackson / mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Landover, MD. 8/2/08 Harmony Memorial Other Specify: Donation 5 22. Name and Address of Facility Signature of Fener Service Licensee 420 H St.NE. B.K. Henry Funeral Chapel Wash., DC. 20002 Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Retroperitoneal hematoma complicating hepatic *x*aminer Due to (or as a consequence of): insufficiency or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, 28a-f, perME, g882 8/20/08 TT tending physician are as the burial -X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 23b. Was decedent pregnant in the Dav Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O þ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Alcohol abuse; Hepatitis C Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sh. performed? death? ✓ Yes 2 No 1 🗸 Yes 2 Nο 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be examiner? Hospital: 1 Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 this ၉ 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28b. Time of Injury 27. Manner of Death Certification: 1 Natural probable fall Yes 2 X No Pending the Funeral Director: apletely filled in by the lunk unk 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) unk unk determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 23, 2008 O.C.M.E. erson who completed cause of death (Item 23a) 30. Name and address of 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year State AUG 0 4 2008

ORIGINAL

Registrar

			For	State of Ma	aryland		ertment of H			giene	2008	25474
			Registrar 1. Decedent's Name (First, Middle	le. Last)		007	imouto or i		2. Date of De			3. Time of Death
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î	/Medic		4a. Facility Name (If not institution		LEL	=	4b City Town or	Location of Death	JULY		2003 ounty of Death	
	Examin	er				2	(7 11 -	7	,	KEN	
	9.0 40.0		CHESTER R 5. Social Security Number	IVER HOSE 6. Sex. 7. Age	ITAL	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th .		nplace (State or Foreign
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	rland ow		10a. State 10b. County	,	10c. City	, Town or Lo	cation					10d. Inside City Limits
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	the noti	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	untry?
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	filed within 72 hours after death with the Maryland Hygiene. Hhydren "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	o- 14	I. Race - Amer	
.0	or ite		1 ☐ Never Married 2 X Mar	Armed Forces? 1 Yes 2 XN If Yes, Give	10		i Tes, specily Cuba i⊡Yes 2. XX No	Specify:	o riican, etc.)		Black, White	7, 816.
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ltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from State	20b. Pi	emetery, crei	sition (Name of matory or other plac	ce)	Date	200. Loca	ation - City or	Town, State
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Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	Licensee Aleller	bei	FI	2. Name and Addres ELLOWS H 30 SPEER	ELFENBEI	N & NEW	NAM FI	UNERAL 21620	HOME
			23a. Part1. Enter the disease, o	or complications that caused	the death							Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or s	a consequ	uerze/f):	Failer	74				
	Examiner			Con	dia	0	Failur	4				
		Jer	Sequentially list conditions, cause. Enter Underlying	Due to (or as a	a conse	uence of):						
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O	ng ph	Med	IF FEMALE:									
Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			☐Ectopic pregnancy	y		23	3d. Date of del Month	livery Day Year
Ш	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	t time of de	eath 5	Other (specify)				World	Day
P.O.	at the	hy	9 Unknown									
	es th igned be de	by	Part II. Other significant condit	lons contributing to death bu	ut not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	equii sen s ould	ted								Yes 2□]NO 3 P	robably 4 Unknown
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<u> </u>	The ate h page	Ю							per 1∐ Yes	formed? 2 X No	death? 1 ☐ Yes	
ij	stan; ertific ctor,	Be (25. Was case referred to medic examiner?	al				26. Place of Dea	ath (Check only	one)		
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Division or Vital Records,	or Att ter de irect	Certification:		mined 28e. Place of inju	ury - At ho c. <i>(Specif</i>)	ome, farm, st y)	reet, factory, office			(Street and own, State)	l Number or Ri	ural Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only	ing Physician: To the best	f examina							
	To the within 2. To the complet	Wed	one) 29b Signature and title of certific	and manner sta	aled.		29c. Licens	se number	1	29d. Date	e signed (Moni	th. Day, Year)
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			30. Name and address of perso	n who completed cause of d		123a) (Type,	20 119	C M	1 Km.	21	6.1.	a ma2112
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			For State Registrar	State of	Maryland /	-	rtment of F		nd Me		0	000	05175
	÷	40	Hegistrar 1. Decedent's Name (First, Middle, Last	st)		001	inicate or i	Dealit	2.	Date of Dea		uug.	3. Time of Death
	Physicia /Medic		Mary Thei	esa Jor	dan				J	Month u1v 22	Day 2008	Year B	1:40 A M
	Examin		4a. Facility Name (If not institution, given 11802 Broadmoor	street and numb	per)		4b. City, Town, o			5		inty of Death	
*	Funeral	-	Social Security Number 6. S		. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Birth	1	nce Geo	orge's lace (State or Foreign ntry)
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	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation			1	,		0d. Inside City Limits
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	or 28%	Direc	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cour	ntry?
	s 23a nust b	Funeral Director	11802 Broadmoo	or Lane	ant Ever in LLS	10.1	207		in? /Snacif	Vos or No-	Unite	ed Stat	es Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? XXXo	-	Was Decedent of H f Yes, specify Cuba I □ Yes 🍇 No	an, Mexican, Specify:	Puerto Rio	an, etc.)		Black, White,	etc.
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Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Patricia Warhur	Type. Print) st (Daug			Page 1				, ,		,
	es 1 and 2 of Health a f item 27 is r other tra		20a. Method of Disposition		20b. Place	OI DISDO	Broadmoo sition (Name of matory or other place	,	ie, Ur Date	per Ma	20c. Location	on - City or To	
im 0	Page nent o		Figure 3 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		rate i	Hi1	1 Cemeter	ry Jul	y 25,	2008	Suit	land.	MD
Baltimore,	permit. Departr Importa any inj		21. Signat un un ce Licer	isee If nic	16.4	22	2. Name and Addre	ss of Facility	Lee F	uneral	l Home	, Inc	6633 01d
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68760,	cate be executed physician and the burial-transit	dical		"d									
Box	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live bir	ome pf pregnancy th 2 □ Fetal dea int at time of death		Ectopic pregnanc Other (specify)	у			23d.	Date of deliver	ery Day Year
P.0	law requires that the de as been signed by the a 2 should be detached		9 Unknown Part II. Other significant conditions	contributing to des	ath but not resulting	in the u	nderlying cause giv	ven in Part I.		23e. Did to	obacco use o	contribute to t	he cause of death?
rds,	w requires to been signer should be of	d by								101	′es 2 XX N	lo 3 ☐ Prot	bably 4 Unknown
Record	law rec as beel 2 shou	Completed								24a. Was		4b. Were auto	opsy findings available impletion of cause of
E B	The ate h page	Com								autop perfo 1∐ Yes	rmed? 21/2 No	death? 1 ☐ Yes	•
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			.t 3DDOA Oth	or:		Check only o			
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ion	Attending Frdeath. ector After by the funer	ation	14 Natural 5 Pending 2 Accident investigation	n	n, Day Year)	Injury		rk?]Yes 2∐1	No				
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	e Hospital 24 hours a e Funeral letely filled	Medical			pest of my knowled sis of examination er stated.								
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier	and maint			29c. Licens	se number			29d. Date si	gned (Month,	Day, Year)
			o skuste	-00			H60	665	-		Ju1y	24,	2008
	(RI		30. Name and dress of person who	completed cause	of death (Item 23a	a) (Type,	Print)						
	, I)D 6 Sta	ate	Dona Leskkuski 31. Date filed (Month, Day, Year)	, M.D. 32	200 Basi	T (0	urt #200,	, Larg	o, MD	2077	74		
	Regist		JUL 2 5	2008	Mus D.	14	The same						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9882 5-7-08 vt. State of Maryland Department of Health and Mental Hygiene Amended Item# = State 19a & 262, M.S. 7/31/08, Kent Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3008 a 28 Pay **Physician** Boyn W. Johnson 900 /Medical 4a. Facility Name (If not inpliquition, give street and number) 4b. City_Town, or Location of Death 4c. County of Death **Examiner** Kives ta Center tertown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under T **Funeral** Months Days Hours Min. 1 □XM 2 □ F 05-25-1925 Maryland Director 215-26-5405 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State ral", or items 23a or 28a-f show Evan inger : ust be notfilled at Chestertown 1X Yes 2 ☐ No MD Kent Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 104 Kennedy Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 □ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Head Custodian Kent County School is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any linjury or other traumatic evonce. Alberta Johnson ပ Unknown 19a. Informant's Name/Relationship (Type. Print) Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620 Frqnees Johnson, 104 Kennedy Drive Chestertown, MD Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-2-08 Pomona Cemetery Chestertown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility muce Bennie Smith FH-717 W. Division St. Dovet, 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PROSTATE CANCER METASTATIC 8 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of, sician and burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ INFECTION URINARY TRACT 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 □Yes 2 No or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 19 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 24 hours rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29c. License number D0041587 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen Suite # 5 ChosperDown MD 21620 Speer Road A. Noble 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month BEATRICE GLORIA KAVAN JIII.Y 20 2008 0642 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL EASTON TALBOT If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🕱 F 83 103-18-3028 APR 11,1925 **NEW YORK** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 545 CYNWOOD DRIVE, APT 208 USA 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES WM. DELAHUNT GRACE B. SHAW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27985 PEACH ORCHARD RD., EASTON, MD 21601 SUSAN K. LEE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7/23/08 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Josep L STROWS h. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Po not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) レロアン Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform

Physician /Medical Examiner

certificate be executed

Box 68760,

P.O.

Records,

or Vital

Division

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

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spital or Attending Physician: hours after death. Ineral Director: After this certifically filled in by the funeral director, p n 24 hours af e Funeral

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural njury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE., EASTON, MD 21601 L 2 3 2008

and manner stated.

31. Date State Registrar

29a Certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:15 p^M July 22 2008 Claudette Charlene Kerns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4355 Begonia Place Charles Brandywine If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗌 M 72 229 38 3832 Aug.8,1935 Wise, Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Charles Brandywine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4355 Begonia Place 20613 US Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Mail Inserter Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dan Fraley Rosa Mullins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Mary Ann Mandley/daughter 4355 Begonia Pl Brandywine, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem 7/29/08 Cheltenham, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic F.H. of Funeral Service Licens Wee-10Nuc 2294 Old Washington Rd Waldorf, MD20601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5000 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes VION 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of De h 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

certificate be executed I or Attending Paffer death. To the Funeral Director: completely filled in by the To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

29b. Signature and title of certific 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day,

4 Homicide

(Check only

29a. Certifier

Medical

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, 2, perFH g884 10/7/08 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** рΜ 7/17/2008 8:10 Janet L. Kimble /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 12703 Kavanaugh Lane Bowie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 1/1/1960 Birthplace (State or Foreign Country) 5. Social Security Number 6022 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Year) Days Hours Min. 1 □ M 2 🗓 F Yrs 477-84-6027 48 TA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 3a or 28a-f show t be notified at 10b. County 10a. State 1 ▼Yes 2 No Director Maryland | Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 20715 USA 12703 Kavanaugh Lane death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: USA or. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than **Environmental** Contractor Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othnary injury or other traumatic event once. Be Paul A. Hewitt Hennrietta Jenkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12703 Kavanaugh Lane Bowie, MD 20715 Samuel Kimble/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 7/26/2008 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer ectal **Physician** - years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2**√** No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 5 ☐ Pending investigation s after dea... eral Director: A' v filled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

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un werny MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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-	he a deg	Sici	1 ☐ Yes 2 🗷		4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath 5	Other (specify,)				WOTH	Day	real
), D	t the	٤	9 Unknown		0.20111101111										
<u>,</u>	stha	by	Part II. Other signifi	icant conditions	contributing to death be	ut not resu	Ilting in the	underlying cause	given in Pa	ırt I.	23e. Did	tobacco	use contribute	to the cause	of death?
ecords,	quire n sig	ᇴ	CHRONIC	OBSTRUC	rive pucha	49A4	13210	32			1 🗆	Yes 2	2 □ No 3 □	Probably 4	☐Unknown
္ဌ	v rec	Completed									24a, Was	c an	24h Mere	autopsy findi	nge available
Ē.	e lav has je 2	윤									auto	opsy formed?	prior death	o completion	of cause of
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VITA	clan ertifi ector	Be	25. Was case referr examiner?	ed to medical	-					ace of Death	(Check only	оле)			
5	Attending Physician: The rideath. cetor: Affer this certificate his by the funeral director, page	၉	1 ☐ Yes 2 🔼	No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatie	ent 3□DOA	Other: 4 🗆	Nursing Ho	me 5□Res	sidence	6 ☐ Other (S	pecify)	
0	ng P	٦	27. Manner of Death		28a. Date of Inju (Month, Da	ry v Year)	28b. Time Injury		njury at Vork?		28d. Describe	how inju	ury occurred		
SION	ath. athe	aţi	1 ☒ Natural 2 ☐ Accident	5 Pending investigation		,,	,,		☐Yes 2	□No					
<u>s</u>	Afte r de ecto by th	Ę.	3 Suicide	6 Could not determine	d 28e. Place of inju	ury - At ho	me, farm, s	treet, factory, offic	e		28f. Location	(Street a	and Number or	Rural Route	Number,
	afte Dire	Certification:	4 Homicide		building, et	c. (Specify	/ /			1	City or To	own, Sta	re)		
	spita ours neral fille	2	29a. Certifier	1 Certifying	Physician: To the best	of my know	wledge des	th occurred at the	e time date	and place	and due to th	e cause	(s) and manne	as stated	
	Fun Fun etely	edical	(Check only one)	2☐ Medical Ex	aminer: On the basis of and manner sta	f examina	tion and/or	investigation, in m	ny opinion,	death occur	red at the time	e, date a	nd place, and	lue to the cau	se(s)
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Mec	29b. Signature and	title of portifier	and manner st	ateu.		200 Line	ense numb	er		204 D	ate signed (Mo	onth Day Var	
	F ≥ F 8	5	290. Signature and	and of certifier	20	,		290. LICI	orise (IUIIID)	01		290. D	ate signed (MC	mini, Day, 102	,
	DS.	1	7	15	Ch	OMC		(3)	0053	703		1	uly	20,2	800
\	MOD		30. Name and addre		o completed cause of d			, Print) Tsi	lon E	Berha	ne, Mi)		20,2	
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State Registrar

31. Date filed (Month, Day, Year)

JUL 2 3 2008 DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** $A^{\,\mathsf{M}}$ July 19 Betty Jane Klima 2008 2:30 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12514 Deer Point Circle Worcester If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Months, Day, Year) Feb. 3, 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. 216-20-2005 82 1926 Director Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland i Hygiene. other than "natural", or items 23a or 28a-f ehow vent, the Madical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Maryland Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Baltimore, Maryland 21215-0036 \U∕U 12514 Deer Point Circle USA 21811 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Insurance permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: if item 27 is marked oth any Injury or other traumatic event 908. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilton Joseph Guilfoy Mildred Grace Matson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt A. Klima/Son 9209 Bay Hill Boulevard, Orlando, FL 32819 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/21/2008 Crematory of Delmarva 4 □ Donation 5 □ Other (Specify) Delmar, Delaware 22. Name and Address of Facility
Zeller Funeral Home, P.O. Box 3171
1212 Old Ocean City Road, Salisbury, MD 21802 21. Signature of Funeral Service I ense enece 23a. Par 1. Enter the disease, or complications that caused the phock, or heart failure. List only one cause on each line. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Adenocarcinoma of Unknown Primary **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ed by the ettending physicien detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Malmonony disense 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes this certificate 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No nours ofter death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Ca 29a. Certifier completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/21/2008 D30619 The 6 MOOuto mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leter S Abbitima Suite 1 10445 Ocean Cry Blud Berlin Maryland 21811 31. Date filed (Month, Day, Year) 32. Disistrar's Signature State JUL 2 2 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland	d / Depa <i>Cei</i>	artment of F	Health and Death	d Mental Hy	/giene Reg. No.		25482
			Decedent's Name (First, Middle, L.)	ast)					2. Date of D	eath		3. Time of Death
н	Physici		JAMES	RONALD	KTRK	PATRIC	CK SR		Month July	30 ,		12:40 A M
100	/Medio Examin		4a. Facility Name (If not institution, g				4b. City, Town, c	or Location of De			County of Death	
		Ü	Frederick Memor	ial Hospit	al		Freder	ick			Frederic	ck
	Funeral			Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 H		irth	9. Birth	place (State or Foreign ntry)
	Director		212-50-1525	1⊠ M 2□ F 5	57	Yrs.	World Days	Tiours III	Novembe			* /
	pu.		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					10d. Inside City Limits
	sho	ក់		-1 -1-	Toc. Oity,							1k Yes 2 □ No
	he M	ect	Maryland Frede 10e. Street and Number	rick		1	rederick			10a Citi	izen of What Cou	ntry?
	with 1	Funeral Director	307 East Patrick St	root Apartmo	ent 2			L701		rog. Oil	United S	•
	eath	era	11. Marital Status	12. Was Decedent		13			(Specify Yes or N	0-	14. Race - Ameri	
	ter d	Ξ	1 ☐ Never Married 2 ☑ Married	Armed Forces	?	, 10.	Was Decedent of I If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White,	
38	urs af		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1⊡Yes 2½∏No	Specify:			Specify: W	hite
21215-0036	2 hou	Completed by	15. Decedent's	Education	- 1	16a. Dece	dent's Usual Occup	pation		16b. Ki	nd of Business/Ir	ndustry
21	hin 7 e. an "r	apr.	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done DO NOT use retire	during most of v d)	vorking			
	ed wil	ő		3		Self	Employed	Т.			ırier Serv	ice
nd	tal H d oth	Be	17. Father's Name (First, Middle, La						lame (First, Middle			
yla	ould I Men arke	မ	Charles E. Kirkpa			1			esa Marie			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship Elizibeth Kirkpatr		r	I	Box 128,				r Town, State, Zi	p Code)
ē,	s 1 a		20a. Method of Disposition		1 00	ace of Dispo	sition (Name of matory or other pla	ce) A	Date	20c. Lo	ocation - City or T	own, State
E	Page nent o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1 I		ret Cemeter	110	gust 2008	Fre	derick, Ma	arvland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Lice	White the second	MO		2. Name and Addre	ess of Facility				-
	H = 6 0		1.000	~			eeney & Bas 06 East Chi				aryland 21	
	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each I	ine. Rcor	NA	of K			arrest,		Approximate Interval Between Onset and Death
7	Examiner			. Buc to (or ac	o a consequ	onde on,						
		je.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	s a consequ	ence of):						
	ficate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	C								
ó	e exer an ar rial-tr	Ĕ	resulting in death) Last	Due to (or as	s a consequ	ence of):						
8760,	ate be nysici ne bu	dical		d								
9	ng ph	Med	IF FEMALE:									
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of deliv Month	very Day Year
۹.	that ned b		Part II. Other significant conditions						23e. Did	tobacco i	use contribute to	the cause of death?
rds	luires n sigi Ild be	Q p	Chronic Ol	placeti	ve	leng	dise	are	1 🗷	Yes 2	□ No 3 □ Pro	bably 4 🗌 Unknown
Vital Records,	w requi	Completed by	Metastatic.	been	dis	eas	e		24a. Wa	s an	24b. Were aut	opsy findings available
Re	he la e has ige 2	E C	7,10(1410)						— aut	opsy formed?	death?	opsy findings available ompletion of cause of
ta	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical					26 Place of I	1 ☐ Yes Death (Check only		1 ☐ Yes	2 No
>	ysician: The is certificate hidirector, page	o Be	examiner?	Hospital:	ient 2 🗆 I	EB/Outnatie	nt 3 DOA Oti	hor:	g Home 5 ☐ Re		6 □Other (Spec	ifu)
of	ding Phys h. After this funeral di	Ë	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o			28d. Describe			y)
Ö	nding th. T: Afte e fun	atio	1 ☑Natural 5 ☐Pending 2 ☐ Accident investigat		ay, Year)	Injury		rk?]Yes 2 □No				
Division	Il or Attendi after death. Director: A d in by the fu	Certification: To	3 Suicide 6 Could not determine	be 28e. Place of Ir building, e	njury - At hor etc. (Specify	me, farm, str	reet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Rui	ral Route Number,
	pital or ours afte eral Dir filled in		29a. Certifier 1 Certifying	Physician: To the bes	t of my know	wieden door	th accurred at the	time date and -1	and due to the	e cource/s	and manner of	etated
	To the Hospital within 24 hours To the Funeral completely filled	Medical		aminer: On the basis and manners	of examinat							
	To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier	and marmer's			29c. Licen	se number		29d. Da	te signed (Month	, Day, Year)
	F ≶ F Ö			How M	$1D \cdot$		MDDO	0054636			gust 1, 20	-
			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type.	Print)					

Registrar DHMH 17 Rev 1/2001

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DIL

State

31. Date filed (Month, Day, Year) AUG - 7 2008

Syed W. Haque M.D. 700 Montclaire Avenue, Frederick, Maryland 21701

32. Registrar's Signature

Please Type or Print in Black Indelible in 8 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ALICE HOPKINS 2008 5:30 MORREN August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Talbot Wing - Heron Point Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕱 F 131-01-1982 93 Oct 5 1914 New York Director Usual Residence of Decedent 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits MD Kent 1 XYes 2 No Director Chestertown 10g. Citizen of What Country? 10e. Street and Number 501 E. Campus Ave. 10f. Zip Code 474 Heron Point 21620 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No White Specify 5 Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Family Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Croes Mary Quigley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan J. Hopkins (daughter) P.O. Box 291 08854 Oldwick, NJ. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/08 4 □ Donation 5 □ Other (Specify) Kent Cremation Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Tylneral Service Licence M00510 118 West Cross St. Galena, MD. 21635 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Suse (Final ALZHEIMERS END STAGE 75 years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ URSTRUCTIVE DISEAS-PULMONARY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1□ Yes 2 No 2**X**No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

P.O. Box 68760, led by the a signed b or Vital Records, page certificate or Attending Physician: director this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Hospitai 2

show 28a-f show notified at

ral", or items 23a or Examiner must be

"natural",

Hygiene.

ould be f Mental F

Pages 1 and 2 should be ment of Health and Ments ant: if item 27 is marked of Health and Menta fitem 27 is marked r other traumatic er

permit. Page Department o Important: if any Injury or ō

Physician

/Medical

burial-transit

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attending ph

Examiner

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the

death \

filed within 72 hours after

Maryland 21215-0036

Baltimore.

State Registrar

Noble, Helen A. M 31. Date filed (Month, Day, Year)

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2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

AUG 0

D Registrar's Signature

122 Speer Rd. Chestertown, MD. 21620

(W)

29c. License number

1)0041587

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 8 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DEBORAH McGUIRE NAU 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of Queen Anne's Inc. Oueen Anne's Centreville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours | Min. | Feb 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 ▼ F 220-82-0400 46 1962 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 TNo Director MD Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27291 Lambs Meadow Rd. 21645 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Nau, Sr. Elizabeth Amrein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod № D 2164 5 Timothy S. McGuire, Sr. (husband) 27291 Lambs Meadow Rd. Kennedyville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State I.U. Cemetery 8/6/08 Worton, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Galena Funeral uneral Servi Home of Stephen L Sch 21635 Schaech M00510 118 West Cross St. Galena, MD. Part Enter the disease, or complical ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician 1eurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infraction cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit resulting in death) Last Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use cogtribute to the cause of death? <u>^</u> 2 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 VINO 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home Hospice 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

David H.

Smith,

M.D.

198 14R.J

32. Registrar's Signature

6602 Church Hill Rd. Chestertown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year A^{M} Julu 25, 2008 7:40 Kathleen F. Meehan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year) March 26, 1946 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday Months Days Hours 1 □ M 2 🕱 F 62 New York 105-38-6853 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Havre de Grace Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21078 Bayland Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc.

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Medical

Specify

Technician

18. Mother's Name (First, Middle, Maiden Surname)

Frances Valego 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.A. Ferris & Co, Inc. 1/26/2008 West Chester, PA

6701 N. Charles ST TOWSON MO 21204

112 J. Bayland Drive, Havre de Grace, MD 21078

(Give kind of work done during most of working life. DO NOT use retired)

White

X-Ray Technician

Specify.

16b. Kind of Business/Industry

20c. Location - City or Town, State

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

112 J.

11. Marital Status

1 ☐ Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Wesley Baker

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a, Informant's Name/Relationship (Type. Print)

James R. Meehan (Husband)

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W Registrar's Signature

If Yes, Give Year or Dates:

College (1-4or 5+)

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mydical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner sician and burial-transit signed by the attending physician I be detached for use as the buria Be Completed by Physician/Medical cate has been signal, page 2 should b within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

21. Signature of Funeral Service Lice	see	22. Name and	Address of Facility Z	ellman F	Funeral Hom	e, P.A.
1 / S. Cal	111					e, MD 21078
23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mode	of dying, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a	IN CANC	ER			Onset and Death
	Due to (or as a consequ	uence of):				
Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):				
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequent	uence of):				
IF FEMALE:	23c. If yes, outcome of pregna	ancy			and Data of	deliver.
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 YNo 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of c	I death 3 Ectopic pre			23d. Date of o	Day Year
Part II. Other significant conditions of MALIGNAN GUND		ulting in the underlying cau	ise given in Part I.			to the cause of death? Probably 4 🗆 Unknown
					opsy prior formed? death	autopsy findings available to completion of cause of ? es 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check onl	one)	^
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA	Other: 4 \(\sum \) Nursing I	lome 5 ☐ Res	sidence 6 ther (S	pecify) WSFLU
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) n	28b. Time of 286 Injury M	c. Injury at Work? 1 ∐Yes 2 ∏No	28d. Describe	how injury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory, o	office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
29a. Certifier (Check only one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation, i	t the time, date and plac n my opinion, death occ	e, and due to th urred at the time	e cause(s) and manne e, date and place, and c	r as stated. due to the cause(s)
29b. Signature and title of certifier	V	29c.	License number S830	3	29d. Date signed (Mo	

DHMH 17 Rev 1/2001

State Registrar AMON

Dorothv Munro

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DOROTHY MUNRO July 19 2008 6:30 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Genesis HealthCare The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Months Days Hours Min. 1 ☐ M 2 🗶 F 183-20-4659 82 JAN 5, 1926 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County rral", or items 23a or 28a-f shov Examiner must be notified at 1**▼**Yes 2 □ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 S. WASHINGTON ST. USA Completed by Funeral 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Dates: WHITE "natural" th and Mental Hygiene.
It is marked other than "natural marked other than "natural mat 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOUTIQUE SHOP SALES CLERK 0 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HANS WELTIN ၉ OAKLEY WELTIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7552 159TH AVE., FOREST LAKE, MN 55025 JOYCE FREDRICKSON/COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7/21/2008 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 21. Signature of Funeral Service License 21-Joseph 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Monic (Arlinoma years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy
performed?

1 Yes 2 No the Hospital or Attending Physician; funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 1)UTCHMANS 31. Date filed (Month, Day, Year State JUL 2 3 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.2008

	1.	For State Registrer	State of Marylan	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	ealth and Death		giene	008	25487
	1.	Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
Physician		Marjorie Helen	McDonnell					July 2	23, ^{Day}	008 Year	2:30 p M
/Medica Examine		. Facility Name (If not institution, give si			4b. City	y, Town, or	Location of Dea			ounty of Deat	
Lxamme		Long View Nursing	Home		,	Manche	ester			arrol1	1
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Und	er 1 Year	If Under 24 Hr		th	9. Birt	thplace (State or Foreign
Director		125-20-7952	м 2 <u>/</u> ДГ 80	Yrs.	Months	s Days	Hours Mir	May 26			w York
D.	U	sual Residence of Decedent									
rylan		Da. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
e Ma	g M	aryland Carroll		M	anche	ester					1 X Yes 2 No
or 26		De. Street and Number			10f. Z	ip Code			10g. Citizer	n of What Co	ountry?
death with the Maryland rms 23e or 28a-1 ehow		3332 Main St.				2110			US		
sep .	In Indian	I. Marital Status	Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dec	edent of His	spanic Origin? (n, Mexican, Pue	Specify Yes or No into Rican, etc.)	- 14.	 Race - Ame Black, Whit 	
or le		1 Never Married 2 Married	1 ☐ Yes 2 ☑No If Yes, Give		1 🗆 Yes	25 X No	Specify:		St	pecify:	-21
ural'	do	3 Widowed 4 Divorced	Year or Dates:	1					1		hite
nat die	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	kind of w	ual Occupa	ition Juring most of wi I	orking	16b. Kind	of Business/	vindustry
withir sne. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)						Most	les Fo	\sim
Hed y		12 7. Father's Name (First, Middle, Last)		Secre	etar	Υ	18 Mother's No	ame (First, Middle			
od of the f	ŭ								, .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Mer Mer	<u> </u>	Lawrence Willia		401 14 111		(2)		e Riha			Tin Condo
h ank le n		9a. Informant's Name/Relationship (Typ	•		•			Rural Route Numb			
and teelth m 27		r. John Yarish	cousin	822 Place of Dispo	Contract of the latest designation of the la	fall V	way We	estminste Date		2115 tion - City or	
F of F	20	Da. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re		cemetery, crei	natory of	other place	9)	Date	200. Loca	tion - City of	TOWN, State
Pa Imen tent: jury		4 □Donation 5 □ Other (Specify)		rroll (Crem	ation	Inc 7	/24/08	Hamps	itead,	Maryland
permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mantal Hygiene. Importent: If item 27 is marked other than "natural" or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinating Item multilest at once.	2	1. Signature of Funeral Service License		4	2. Name : 12. Wa	and Addres ashin	^{s of Facility} Pr: otton Rd	itts Fund • Westmir	eral E nster,	lome &	Chapel, PA 21157
	2	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deal								Approximate Interval Between
Medical Examiner (Medical Examiner (Me prival-transit and streep pri	Examiner and See See	inmediate Cause (Final isease or condition esulting in death) a. dequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury hat initiated events soulting in death) Last	Due to (or as a consecutive of the Due to (or as a secutive of	Juance 1/1:	dir	7	nli				Onset and Death
the b	dicar	d.									
nding use a	E IF	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnant in Live birth 2 ☐ Feta 4☐ Pregnant at time of o	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)			230	d. Date of de Month	livery Day Year
w requires thet the death been signed by the ette should be detached for	<u>ک</u> ا	art II. Other significant conditions con		sulting in the u	ndertying	cause give	n in Part I.		obacco use		o the cause of denth?
Physicien: The law re rthis certificate has bee rral director, page 2 sho	Completed	Ostroporo	200					24a. Was auto perfo 1 Yes	psy prmed2	prior to death?	utopsy findings available completion of cause of
striffic ctor,		5. Was case referred to medical examiner?					26. Place of D	eath Check only	one		
Physicien: r this certific ral director,	<u> </u>	1 ☐ Yes 2 ☑ No		ER/Outpaties	nt 3 🗆 [4 Nursing	Home 5 ☐ Resi	dence 6	□Other (Spe	ecify)
ding Pt. h. After th		7. Mayner of Death 1 5 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f	28c. Injury Work	at ?	28d. Describe	how injury o	occurred	
auth. or: Al	a Tie	2 Accident investigation			М		res 2 □ No				
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral to the funeral orders.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, facto	ory, office		28f. Location (City or To	Street and I wn, State)	Vumber or R	ural Route Number,
e Hospin 24 hour Eunera letely fills			er: On the best of my knier: On the basis of examination and manner stated.								
To th To th		9b. Signature and title of certifier		,	2	9c. License	number		29d. Date :	signed (Mont	th, Day, Year)
) ()				Dios	1763		7/	2/100/	
MIL	31	0. Name and address of person who cor	mpleted cause of death (Ite	m 23a) (Type.					1/6	1100	
5		Dr. Ernesto Mendoz				RA G	Sui+a 11	20 Westr	ningto	MT MT	21157
State	_	1. Date filed (Month, Day, Year)	32. Regetrar's Sign	ature			-u. L.	LV MESU	عاصبت		
Registra		.1111 2 5 2	nna Maria	K	Ano.	K.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1510 PM JUL 2000 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ditc/Center 1 town Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 12€M 2□F 218.36.3417 Director 19.39 10 mi 11 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Chestertown mo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Race - American Indian, 8596 CAUIKGIELD 21620 death iral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any injury or other traumattc event, the Medical Examiner. They Forces?

☐ Yes 2 ▼ No
Yes, Give
Year or Dates: 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTIO Guardian Construction Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Houston Grinnell AZINE MOORE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8596 CAURFIELD Rd Chestertown, mo 21620 IRENE MOORE-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. George U.m. 8-2-08 worten, mD 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Konneth walley Tuneral Service ally 00026 821 W. ST. Annapolis, maryland 21401 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ĮQ. in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has birector, page 2 s autopsy performed 2 12 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director. p neral Director: After this filled in by the funeral d

State Registrar

Allen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D21313

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUE Chestedown Md 2/620

State of Maryland / Department of Health and Mental Hygiene

Physician Mode A Ficility Name of not analyzing, we siref and number) 44 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location of Death Finding George's By Hypertain 45 - City, Term or Location 45 - City				_	For State Registrar	State	of Mary	/land / De <i>C</i>	oartmer ertifica					Reg. No	00	0.08	25	1,9
Prince George 's Nospital Center Fundad Director Type 5-05-18 Stock S					Alice K. Martin	n			,				2. Date of De Month July 1	L9, 2			3. Time 6	_
STO-68-0518 County Store		Ex	xamin	er	Prince George's	s Hospita	l Cent		Che	ver13	7			Pr	-	e Geo	orge's	
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Physician / Medical Examiner 23a. Faff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proposed of the property of the p	land 2	Ild be filed vental Hygie	tlc event, th	Be	17. Father's Name (First, Middle			Clain	is FIO	cesso	18. Mothe			e, Maider				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Divisio	tal or Attend s after death al Director: /	ed in by the f	Certificati	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac					Yes 2							ımber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		the Hospit nin 24 hour the Funer	npletely fill		(Check only 2 Medica one)	I Examiner: On the and ma	basis of ex	amination and/o	rinvestigatio	n, in my o	pinion, de	nd place, ath occurr	and due to the	e, date ar	nd place	, and due	to the cause	
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08-05908 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 25491 Jonathan M. Mclaughlin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day August 2, 2008 0647 hrs Medical Examiner Mclaughlin Jonathan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1309 Lexington Street Salisbury Wicomico If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director $_{1}X_{M}$ 12/09/1966 Country) Maryland 218-62-7019 41 2 Usual Residence of Decedent 'n 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show Maryland Wicomico Salisbury hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 1309 Lexington Street IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? Never Married 2 X Married White, etc. 1 Yes 2 X No specify: Widowed Divorced If Yes, Give Year Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. nnt: If item 27 is marked other than Self Employed Carpenter 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be David Mclaughlin Carolyn Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Mclaughlin/wife 309 Lexington Street Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: Salisbury Crematory Donation 5 Other Specify 08/08/2008 Salisbury, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home P.A. Rd Salisbury, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Alcohol and oxycodone intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last executed Physician/Medical AMENDED 23a, 27, 28a-f, perME, g882 8/14/08 TT XUNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 2 ✓ No 3 Probably 4 Unknown leted 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of Compl certificate has performed? death? ✓ Yes 2 No ✓ Yes No te Hospital or Attending Physician: Tin 24 hours after death.

The Funeral Director: After this certifica pletely filled in by the funeral director, pr 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No unk Pending Fnd 8/2/08 Fnd 6:40 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1309 Lexington St. Salisbury, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined 124 hours a (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only within 2. To the F 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) O.C.M.E. August 3, 2008 30. Name and address of person who completed cause of death (Item 23a)

Registral
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State

Margarita Korell MD.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. F

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			For		State of Ma	arylan		•		nd Mental Hy	/giene	2009	3 25492
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	Examin	er	Memoria	1 1	sital			Eas	1			albot	
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	ow at			0b. County		10c. City	, Town	or Location					10d. Inside City Limits
	a-f sh	ctor	MD	Dorches	ster		Can	bridge					1 ∐Yes 2 X No
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2	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15 (Specify	5. Decedent's E	ducation ade completed)		16a. [Decedent's Usual O Give kind of work d life. DO NOT use re	cupation one during most o	f working	16b. Kii	nd of Business	/Industry
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ary			19a. Informant's Name		(Type. Print)		19b.	Mailing Address (St.		or Rural Route Num	ber, City o	r Town, State,	Zip Code)
			Philip Ca		ılkus hus					bridge, M			
Baltimore,	Pages 1 nent of He int: If iten iny or oth			Cremation 3	☐Removal from State	C	emetery	Disposition (Name of crematory or other	place)	Date		cation - City or	
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Ba	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		B	k R	11300					Thomas Fu ambridge, M			P.A.
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	/Medical Examiner		resulting in death)		Due to (or as	a consequ	uence of	f):					
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1[(Check only 2[one)	☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	f examina	wiedge, tion and	death occurred at the control of the	ne time, dat <i>e</i> and my opinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the	Me	29b. Signature and titl	le of certifier	**			29c. Lie	ense number		29d. Dat	e signed (Mon	th, Day, Year)
			1 / XIII	San	1,m			Da	D5976	. 2	71	20/0	3
			30. Name and address	s of person who	completed cause of d	eath (Item	23a) (T	ype, Print)	L		210	1.05	
			31. Date filed (Month,	Day Voarl	32 Registr	ar's Signs	ture	2-05	DU IN	V .	110	001	
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Registrar

State

31. Date filed (Month, Day,

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Vear Month John Joseph Noonan 4:08 P M 21, 2008 /Medical Ju1v 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mount Airy Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 → XM 2 □ F Days Hours Yrs 080-12-4320 Director 92 April 16, 1916 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1220 Leafy Hollow Circle 21771 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: White 3X Widowed 4 □ Divorced WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Secondary (0-12) College (1-4or 5+) City of Rockville 12 Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Noonan ပ Mary McAloon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 19a. Informant's Name/Relationship (Type, Print) Dana M. Tievy - Granddaughter 1220 Leafy Hollow Circle, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Parklawn Memorial Park 7/25/08 4 Denation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Full eral Services icense Kovere 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** MYELODYSPLASTIC disease or condition resulting in death) SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Yes a linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a, Was an has autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 🗺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) ひょこりょうく July 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

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	419 Severnside Drive	Severr	na Park	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Ag	(In yrs. last birthday) If Under 1 Year Months Days	Hours Min. (Month, Day,	
70	Usual Residence of Decedent 10a. State 10b. County Montgorery	10c. City, Town or Location	Sep. 28	10d. Inside City Limits
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 9906 Julliard Drive—11003 Sweetmeadow Drive—	VE 10f. Zip Code	20817	g. Citizen of What Country? USA
ter dea	11. Marital Status 1 □ Never Married 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ X	Ever in U.S. 13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 d within 72 hours after glene. er than "natural", or ite, the Medical Examine.	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 ▼No	Specify:	Specify: White
21215-00 ed within 72 hou ygiene. For than "naturat, the Medical E	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation 1 during most of working d)	6b. Kind of Business/Industry Performance and
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and d be flic and oth ed oth evenul	17. Father's Name (First, Middle, Last) Edward Tenley Smith		18. Mother's Name (First, Middle, M Edith Schroel	· ·
Maryland nd 2 should be file tith and Mental Hy Z7 is marked oth r traumatic event	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street	and Number or Rural Route Number,	
e, M 1 and 2 Health a em 27 L	Patricia Child/ Daughter 20a. Method of Disposition		de Drive Severna P	
morrages Pages on of her of her of you of	1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other pla Atlantic Cremator	July 19, ha	20c. Location - City or Town, State Len Burnie, Maryland
Baltimore, permit. Pages 1 a Department of Hee Important: If Item any injury or othe	21. Signature of Funeral Service-Licensee		2000	ma Park Funeral Home
m goras	23a. Pann. Enter the disease, or complications that caused	495 Gov. F	<u>Ritchie Hwy, Sever</u>	ma Park, MD 21146
Physician	shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	ne. Ho	of Failure	Interval Between Onset and Peath
/Medical Examiner	resulting in death)	a con equence (i):	Sland Plant	7 4 114 4
Je.	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	tear on	an gran
60, e executed ian and urial-transit Examiner		t	type tem	w year
68760, ufficate be exe g physician a as the burial-	d d	a consequence of):	1.*	
c 6876 rrificate be ing physici s as the bu	IF FEMALE:			
P.O. Box 6876 nat the death certificate b d by the attending physic etached for use as the b Physician/Medica	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnance	У	23d. Date of delivery Month Day Year
that the de detached for the year detached for year detached for the year detached for the year detached for y	1 ☐ Yes 2 DNo 4 ☐ Pregnant at 9 ☐ Unknown	Sill of death Sill of the Capechy _		
	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause giv	en in Part I. 23e. Did toba	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
al Record The law requir cate has been si page 2 should			24a. Was an	
Vital Relations The Incertificate he ector, page	05.11		perform 1□ Yes 2	ed? death? No 1 Yes 2 No
or Vita Physician: this certifica	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatient 3 DOA Oth	26. Place of Death (Check only one er: 4 ☐ Nursing Home 5 ♣ Resider	Deughters 6 Mother (Specify Residence
On Of ding Phy. h. After thi funeral cure. Tion: T	27. Manner of Death 1 Natural 5 □ Pending (Month, Da	y Year) Injury Wor	y at 28d. Describe how	
Visi Atten Pr deat ector: by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injuding, et	ury - At home, farm, street, factory, office	Yes 2 □ No 28f. Location (Stre	eet and Number or Rural Route Number,
Div Hospital or A 24 hours after Funeral Direc tely filled in by			City or Town,	
Director the Hospital or within 24 hours after to the Funeral Director completely filled in	29a. Certifier (Check only one) 1	of my knowledge, death occurred at the ti f examination and/or investigation, in my dated.	me, date and place, and due to the call pinion, death occurred at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
To the within 2 To the complete complete Med	29b. Signature and title of certifie	Quality 29c. Licens	2 i 4 3 8	Date signed (Month, Day, Year)
CATO.	34. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print) W V (ENSE HIGHWA	ANNAPOLIMATIKU
State Registrar	31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature		

DHMH 17 Rev 1/2001

Registrar

JUL 2 3 2008

Director

Funeral

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Completed

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Physician

/Medical

Examiner

Funeral

Director

= State Registrar				Cer	tificate of De	eath	R	leg. No. 2	10 251.95
	me (First, Middle, Las	*				,	2. Date of Death Month		Year 3. Time of Death
Carroll	l J. Patte	n				·	1 1	30 200	
	(If not institution, give	street and number	r)		4b. City, Town, or Loc	cation of Death)	4c. County of	1
Memo		spital			Easton	· · · · · · · · · · · · · · · · · · ·	- Chinah	Talla	V ·
Social Security I	4616 ¹³	ex 7.A X M 2 □ F	Age (In yrs. last birt	rthday) _ Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 10	(, Year)	9. Birthplace (State or Foreign Country) Maryland
Jsual Residence o 0a. State	of Decedent 10b. County		10c. City, Town	n or Loc	eation				10d. Inside City Limits
MD	Caroline	<u> </u>	Ridge						1 □Yes 2 No
0e. Street and Nu	umber				10f. Zip Code		1	10g. Citizen of Wha	nat Country?
	Stevenson 1	Road			21660			USA	W. 2001
1. Marital Status		12. Was Deceden	nt Ever in U.S.	13. V	Vas Decedent of Hispa	anic Origin? (Sr	Decify Yes or No-	14. Race -	- American Indian,
	rried 2 Married	Armed Forces 1 X Yes 2 ☐	s? ⊒No_	lf '	f Yes, specify Cuban, N	Mexican, Puerto	Rican, etc.)		, White, etc.
	4 Divorced	If Yes, Give Year or Dates:	Korean	11	□Yes 2∏ No S	Specify:		Specify:	White
(\$0.	15. Decedent's Edu	lucation	Wa I 16a.		lent's Usual Occupation			16b. Kind of Busin	
(Spe	ecify only highest grad condary (0-12)	de completed) College (1-4or	r 5+)	(Give kind of work done during most of work life. DO NOT use retired)				Martin (G. Imbach Construction
Eloniana	Jirda, y (=,	3	01)	Job	Superinte	ndent		_	Company
	e (First, Middle, Last)						ne (First, Middle, N	Maiden Surname)	
William	n F. Patter	n				Delores	A. Ridg	jell	
_	Name/Relationship (7	**	19b	. Mailing	g Address (Street and	Number or Rui	ral Route Number	r, City or Town, St	tate, Zip Code)
Mark B.	Patten/ So	on			4 Stevenson	n Road '	Ridgely,	MD 2166	50
20a. Method of Dis			20b. Place of cemete	f Dispos	sition (Name of natory or other place) Memorial		, 22	20c. Location - Ci	•
	2 ☐ Cremation 3 ☐ I i 5 ☐ Other <i>(Specify</i>)		Lakemo Garden	'nt 1	Memorial	July 2008	\mathbb{R}^{23} , \mathbb{D}	Javidsonv	ville, MD
	Funeral Service Licens		Our	Bä	Name and Address of arranco &	Sons, P.	.A. Seve	rna Park	k Funeral Home k, MD 21146
23a. Part 1. Enter	the disease, or comr	olications that caus	ed the death. Do		er the mode of dying, s				Approximate
Immediate Cause	eart failure. List only o e (Final	one cause on eauri	line.		0				Interval Between Onset and Death
disease or condition resulting in death)	tion	a. Aran (or s	as a construence of	-0.	Jepas				Novers
		Ocean	s a consequence	ot):	Ca. ene-				Ans
equentially list or	onditions,	b. Oue to (or a	as a consequence of	0.1	Jev- ~				Show
Sequentially list contains to include the contains to include the contains to include the contains to the contains the con	erlying or injury	che	ma The	~ 2					dus.
that initiated event resulting in death)	115	c. Due to (or a	as a consequence of	of):	5				- 2
		In	a cane	92	Smel	l cel	1		weeks
		.d <i>C</i>	<i></i>		7		L		
in the past 12 1 ☐ Yes 2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No							,	
9 Unknowr					-tuon i	~	no- Didto	- contrib	the state of death?
Card	ificant conditions co	intributing to deau	but not resulting in	i the unc	derlying cause given in	Part I.	23e. Did tob		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Coren	my a	tery	disers.	e	lis	Puso	24a. Was ar autops perform	sy prid med? dea	ere autopsy findings available ior to completion of cause of eath?
25. Was case refer	me cu	Sycien	e pro	rve	7	Dag	1 ☐ Yes 2	2 No 1	□Yes 2 □No
examiner?	-	Hospital: 1 Inpat		tiont	Other:		th <i>(Check only one</i>	•	
It then my	1110	The Property	ttient 2 ☐ ER/Out		1 3LI BOA 2			ence 6 Other	
27. Manner of Dea		28a. Date of In	jury 28b. i	Time of Injury	28c. Injury at Work?		28d. Describe ho	ow injury occurred	1
27. Manner of Dea 1. Natural 2 Accident 3 Suicide	ath 5 ☐ Pending investigation 6 ☐ Could not be	(Month, D	njury 28b. T	Injury	M 1 ☐ Yes	s 2□No			r or Rural Route Number,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examinar must be notified at 4 Donation Signature of F the 23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list concause. Enter Under Cause (Disease or that initiated events resulting in death) I Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Physician/Medical IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 s been signed by the should be detached 9 Unknown þ Completed certificate has b rector, page 2 st Chr After this certific funeral director, I 25. Was case referexaminer? Medical Certification: To Be 27. Manner of Deat 1. Natural 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 🗌 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aut w. Norte, W Z (9 S. Weshington St. Zastin

State Registrar Drul

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** Henrietta Louise Potter 2008 26 8:55 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood Nursing Home Williamsport Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 079-16-9247 94 Director 08/28/1913 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Director Washington Williamsport 1 □Yes 2XINo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue, C55 21795 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Betts, Jr. Ida E. Repp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Rinn / Daughter 67 Brightwood Drive, Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 07/27/2008 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerebrovascular week /Medical Due to (or as a consequence of) Examiner Due to lor as a consequence of Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteo porosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 University Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuther-Sands, ap D47451 July 26, 2008 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Nursing Home, 16505 Virginia Avenue

JH-4 State

31. Date filed (Month, Day, Year) JUL 2 9 2008

Cynthia Kuttner-



Sands mD

Registrar

William sport,

Maryland 21795

			For State	State of Maryla		artment of H r <i>tificate of L</i>		lental Hygie	ene	3 25500	
		1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death	
	Physici: /Medic		David Pau	ı1 Ro11s			Month 08	01 ő8	1220 а.м		
4	Examin		4a. Facility Name (If not institution, give WMHS Braddock C	· ·	4b. City, Town, or Cumber	Location of Death		4c. County of Death Allegany			
	Funeral		5. Social Security Number 6. S	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign			
	Director		215-46-1888	M 2□F 61	Yrs.	Months Days	Hours Min.	(Month, Day,) March 16		shington,DC	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits	
ire, Maryland 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland	Maryl I-f sho		WV Mineral Burlington								
	or 28s	Director	10e. Street and Number		Durin	10f. Zip Code		100	g. Citizen of What C	ountry?	
	s 23a		Rt. 1, Box 128-			2671		- '' \ \ \ \ \ -	USA		
	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity yes or No- Rican, etc.)	14. Race - Am Black, Whi		
	ral",o	d b	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:		Specify: W	hite	
	"natu	letec	15. Decedent's Ed (Specify only highest gra	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing 16	16b. Kind of Business/Industry			
2121	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sergeant/Deputy				County Sheriff		
e filed al Hyg	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, I						Middle, Maiden Surname)		
Maryland	Ment Ment arked	2	George Marcus R						Pritchard		
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (City or Town, State,		
	f Heal f Heal item 2 other		John M. Rolls/Br 20a. Method of Disposition		b. Place of Dispo	6 Hempsto sition (Name of	one Avenu	e Pooles	oc. Location - City o) 20837 r Town, State	
altımore,			1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			natory`or other plac erland Cre	i	Aug	Cumberla	nd, MD	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer			2. Name and Address		# C U.U.	eral Home		
_	å∩ ⊑ m o		Rt. 2, Box 1-A Burlington, WV 26710								
	Dharisian		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and DIFFUSE LARGE B CELL LYMPHOM A Onset and Death Cause (Final disease or condition) a. DIFFUSE LARGE B CELL LYMPHOM A Onset and Death Cause (Final disease).								
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons		TRUL 1) CEU	11717	1/0-711	JAN2008	
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9	certificanding phase as the		IF FEMALE:	00-16						-	
ROX	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			y			23d. Date of delivery Month Day Year	
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s,	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?		
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ě	2 8 8	Completed						24a. Was an autopsy performe	ed? prior to	autopsy findings available o completion of cause of	
Vital Records,	ding Physlcian: The law h. h. After this certificate has b. funeral director, page 2 sl		25. Was case referred to medical			_	26. Place of Deat			es 2 No	
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In OT ing Phy After this	ling P		27, Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
DIVISION	Attend death ctor: ,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be		Yes 2□No	28f. Location (Street and Number or Rural Route Number,					
2	al or / s after al Dire ed in b	Serti	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town, State)		
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, to	Medical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the comple	ğ	29b. Signature and title of certifier	29c. License number 29c			9d. Date signed (Month, Day, Year)				
				- UVY		Das	3371		8-1-	08	
	10	Ì	30. Name and address of person who			Print)	Cural	o.cland	200 21	400	
	Sta	te	DR. Gamar 31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	100 UVIV	e curne	ser factor,	MD XI	50 &	
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